S. HRG. 98-957

MEDICARE HOME HEALTH BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

JUNE 22, 1984

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MEDICARE HOME HEALTH BENEFIT

FRIDAY, JUNE 22, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 2:03 p.m. in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing and the prepared statements of Senators Dole, Durenberger, Heinz and Bentsen follow:]

[Press Release No. 84-145]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON THE MEDICARE HOME HEALTH BENEFIT

Senator Dave Durenberger (R. Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the Medicare home health benefit and the current difficulties in interpreting the intermittent care rule.

The hearing will be held on Friday, June 22, 1984, beginning at 2:00 p.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger noted that "home health benefits are an important part of the Medicare program as well as one of its fastest growing components. Over the past several years, the Congress has demonstrated an interest in making home health care benefits more available and has succeeded in increasing utilization. However, questions about the nature of the benefit, the cost of the service, and the rules governing its delivery, have continued to arise.

Most recently the industry and various Members of Congress have raised questions about the provision of intermittent services. It has been suggested that the guidelines for administering the benefit are confusing and often inconsistently applied."

Senator Durenberger noted that the Subcommittee is interested in identifying the nature of the concerns that have been raised, the reaction of the Administration to these concerns, and the possible solutions to the problem.

"The Subcommittee is interested in hearing from the Administration, intermediaries, home health care providers, and others interested in this issue. We are eager to assure older Americans that home care will be available when appropriate, on a fair and equitable basis."

OPENING STATEMENT OF SENATOR BOB DOLE

For some years now we have been struggling with the home health care benefit under the medicare program. How to define it, how to encourage its use, how to finance it, and finally, how to control it.

Home health care benefits are now one of the fastest growing components of the medicare program. In fact, in 1985, medicare will spend $2.2 billion for home care, an increase in one year of 15.8 percent.

Members of Congress have recently been hearing complaints from providers of home health services on the issue of the definition of intermittent care. Officials of the Health Care Financing Administration have been wrestling with the problem, and there have been a number of legislative solutions proposed in response to it. In fact, one such legislative proposal is in our deficit reduction package, H.R. 4170. However, it is not yet clear what the exact nature of the problem is concerning intermittent care, nor what would be the best solution.

Today I am pleased that all of the parties who have a special interest in the medicare home health benefit have joined us at this hearing. We will hear from officials of the Health Care Financing Administration, from home health care providers, and from fiscal intermediaries. I welcome the opportunity to better understand this issue, and I hope that we will be better advised by all of you on a suitable course of action.

Opening Statement by Senator Dave Durenberger

Home health care is one of the fastest growing industries in the health care marketplace today. Even Business Week has reported on the promising potential of the home-care industry. One analyst estimates that the current $7 billion market will grow to a $19 billion business by 1990. Another article reported on the push by insurance companies to encourage the greater use of home health services as opposed to expensive hospital stays. The interest in home health is a direct result of the increased attention to price in health care, not only by government but by all payers of health care services.

Medicare, the government's health insurance program for the elderly and certain disabled persons, also provides coverage for home health services. In 1981 Medicare outlays for home health care were about $1 billion accounting for 2.4% of total Medicare outlays and it too is growing. The Trustees of the Medicare program estimate that between 1981 and 1982 reimbursements for home health services are expected to increase by 48% and by 1989, reimbursement will reach $3.2 billion.

Several changes in the Medicare home health benefit have occurred over the last few years causing some concern for home health agencies. The most recent change was HCFA's clarification of its definition for the "intermittent care" requirement for home health care coverage which limits the number of daily visits for home health services to a three week period.

The new Medicare prospective payment system has at the same time, introduced incentives for hospitals to discharge patients as soon as it is medically possible. What this means is an increased demand for home health services at the same time when HCFA is restricting the use of the Medicare home health care benefit. What HCFA appears to be doing is limiting the supply of home health services in order to control costs.

What I envision in the near future will do away with these and other complications imposed by HCFA's definition and redefinition of the rules and regulations governing the Medicare program. The appropriate way to contain costs is to develop a financing system that assures the appropriate substitution of services so that the money saved on the hospital side is put into home health care.

What I would like to see is the expansion of the DRG system to include skilled nursing facilities, physician services, and home health care. One payment would be made to a health plan to manage patient care for an entire spell of illness. Home health agencies would contract with the plan for needed health care services. Home health agencies would fare well under this approach as health plans would now have the financial incentive to provide quality health care in the most cost-effective environment.

With this future goal in mind—of a comprehensive Medicare voucher program—I look forward to hearing from the witnesses today about the current problems faced by home health agencies in the interpretation of HCFA's "intermittent" requirement for home health care services.

Opening Statement of Senator Lloyd Bentsen

Mr. Chairman, we are privileged this afternoon to have with us two witnesses from Texas, each of whom brings a special perspective to the successful operation of home health services. Mary Suther will be speaking on behalf of the national Association for Home Care, which represents more than 2000 home health providers in each of the 50 states. Her grasp of the difficulties encountered by agencies as they attempt to operate under the current HCFA (pronounced hic-fa) interpretation of

the term "intermittent care" are especially revealing in that HOMECARE has been able to document, on a national basis, widespread inconsistencies and unjustified restrictions in reimbursement for home health services. I find particularly compelling her recommendation that we begin to move away from any arbitrary limits on length of care and toward a clinical definition of diagnoses and conditions that warrant coverage under the home health provisions of Medicare.

Eddie Bernice Johnson, Executive Officer of the Dallas Visiting Nurses Association, is uniquely qualified to speak about the Dallas VNA experience with ambiguous interpretations of the term "intermittent care." Not only does her agency cover an 11 county area which includes both urban and rural regions, but VNA has been in the business of delivering home care to Dallas and the surrounding communities for more than 50 years. VNA works closely with local physicians and hospitals and is certified to render care under both the Medicare and Medicaid programs.

Mrs. Johnson's testimony should provide the Committee an historical perspective on the changes in the administration of home health services under Medicare. Because of her special relationship with the communities in which her agency operates—she served three terms in the Texas State Legislature and was Regional Administrator of the Department of Health, Education and Welfare under President Carter—Eddie Bernice has witnessed first hand the increase in severity of illness among patients discharged into her agency's care since DRG's became the basis of hospital payment under Medicare.

Together the testimony of these witnesses should persuade even the most skeptical among us that home health services have assumed an even more important role as part of a comprehensive health care system for the elderly and disabled. Adequate reimbursement for home health agencies and consistent application of clear payment guidelines is fundamental to quality health care under the Medicare program. It is time we resolve the ambiguities surrounding the term "intermittent care."

Opening Statement of Senator John Heinz

Mr. Chairman, I would like to commend you for focusing the Subcommittee's attention on an issue of utmost importance. I believe, and I know you agree, that it is essential to take a comprehensive look at the way Medicare's home health benefit is administered. If administered correctly, this benefit can improve the health of our elderly population and reduce the cost of care. But the fact is we are failing to provide urgently needed home care to those who need it most. We are failing to administer the program in a fair and consistent manner. And, we are failing in our oversight responsibilities because we don't collect the data needed to assess either utilization or cost.

At today's hearing we will look at the definition of "intermittent care". I hope it will enable us to move expeditiously toward fair, consistent and humane administration of the home health benefit—before it's too late!

I'd like to note at the outset, Mr. Chairman, that I am somewhat surprised by the Committee's timing for this hearing. Once again, as in the case of health insurance for the unemployed, we seem to be a day late and a dollar short. Here we sit "studying" this issue nearly 6 months after Senator Bentsen and I introduced S. 2338, the Home Care Protection Act, and over 2 months since the Senate adopted my compromise, emergency home care amendment to the Deficit Reduction package.

I don't claim that our bill solves all of the problems in administering intermittent home care. It was meant to be stopgap measure, to correct the problem of varied interpretations of a HCFA transmittal that, in effect, restricts reimbursement for intermittent care. While I am told that this transmittal was not intended to be used to limit coverage in any absolute sense, many fiscal intermediaries have imposed new ceilings on coverage.

As a consequence, there is a disparity in the way in which benefits are administered. In some states, for example, daily care still means no more than 3 days a week, while in others it means up to 7 days a week. Reimbursement for home health care seems to depend more on the agency's or the intermediary's guess as to what Medicare will cover than on the medical condition of the Medicare beneficiary. Surely, Congress did not intend for the Medicare benefit to be administered in the relatively arbitrary, inconsistent and somewhat capricious manner.

Mr. Chairman, S. 2338 would help to correct this problem. First, it would assure Medicare beneficiaries of their entitlement to medically necessary home care. Second, it would help to prevent unnecessary and cost hospital and nursing home admissions and readmissions. Third, it would respond to a new "care gap" that was

inadverently created by the DRG system—a system that gives hospitals incentives to reduce lengthy inpatient stays by placing patients back into the community even when they still may need a high degree of skilled cared at home.

I understand that the Administration is opposed to S. 2338 and the modified version agreed to by the Senate. Apparently, opponents of home care legislation have three major concerns. First, they feel that the legislation would "liberalize" the benefit at a time when we should contain costs. Second, they argue for the overall need to control excessive utilization. And third, they say we haven't the data needed to assess the potential impact of such a legislative change on either utilization or cost.

In response to these concerns, let me say this: no one here today, least of all myself, would argue against a prudent and well-designed all-out effort to improve the administration of this benefit. It seems to me that the opponents of even the modified Senate home care amendment are taking the short-sighted approach by slashing this program, when they could be looking for more rational ways to prevent mismanagement of Medicare's home health benefit.

So, I hope today we can come to some agreement about the nature of the problem, the extent of what we do and what we don't know about utilization and cost, so that we can move quickly to clean up the program. I hope that as a result of today's hearing, the Department of Health and Human Services will gather whatever information is needed to run this program in a more efficient and more humane way. I would recommend that, at a bare minimum, the conferees on the Deficit/Reduction package include language to ensure that this in fact happens. Otherwise, we will find ourselves in this same boat year after year when these problems inevitably reoccur.

Senator DURENBERGER. The hearing will come to order. The home health care is one of the fastest growing industries in the health care marketplace today. Even Business Week has reported on the promising potential of the home care industry. One analyst estimates that the current $7 million market will grow to $19 billion by 1990. Another article reported on the push by insurance companies to encourage greater use of home health services as opposed to expensive hospital stays.

The interest in home health is a direct result of the increased attention to price in health care. Not only by Government, but by all payers of health care services.

Medicare, the Government's health insurance program for the elderly and certain disabled persons, also provides coverage for home health services. In 1981, medicare outlays for home health care were about $1 billion, accounting for 2.4 percent of total medicare outlays. And it, too, is growing.

The trustees of the medicare program estimate that between 1981 and 1982 reimbursements for home health services were expected to increase by 48 percent and by 1989, reimbursement will reach $3.2 billion.

Several changes in the medicare home health benefit has occurred over the last few years, causing some concern particularly for home health agencies. The most recent change was HCFA's clarification of its definition for the intermittent care requirement for home health care coverage. This change was intended to provide for uniformity in coverage for home health services throughout the country.

Another concern for home health agencies is the new medicare prospective payment system. Under this new system incentives exist for hospitals to discharge patients as soon as it is medically possible. What this means is an increased demand for home health services. And home health agencies are beginning to see sicker patients as well.

What I envision in the near future will do away with these and other complications imposed by HCFA's definition and redefinition of the rules and regulations governing the medicare program. It seems to me the most appropriate way to contain cost is to develop a financing system that assures the appropriate substitution of services so that the money saved on the hospital side is put into home health care.

What I would like to see, as most of you know, is the expansion of the medicare payments system to include skilled nursing facilities, physician services and home health care. One payment would be made to a health plan to manage patient care for an entire spell of illness. Home health agencies would contract with the plan for needed health care services. Home health agencies would fair well under this approach, as health plans would now have the financial incentive to provide quality, cost effective health care.

As an alternative to a lump-sum payment for an episode of illness is the development of a voucher approach to assure the more appropriate substitution of services. That's why people on this subcommittee feel so strongly about the experimentations and the demonstrations proposed for social HMO's to move into the direction of a voucher type of system.

With this future goal in mind, I look forward to hearing from the witnesses today about the current problems faced by home health agencies in the interpretation of HCFA's intermittent requirement for home health services.

I have an opening statement also from Senator Bob Dole, the chairman of the Finance Committee and Senator John Heinz, which will be made part of the record at this time. And speaking of Senator Heinz, I also have a note that says that late in the night while everybody was tired, the Senate conferees on H.R. 4170 receded on the Heinz amendment, the H.R. 4170, which many of us on this committee supported. And that does not come as good news to many of you in this room.

So we will begin our hearing with our first witness who will take on the little statement I had in there about HCFA's motivations—Patrice Feinstein, Associate Administrator for Policy, Health Care Financing Administration, Washington, DC, and Baltimore, MD.

STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC ACCOMPANIED BY MARTIN KAPPERT AND ROBERT STRIMER

Ms. FEINSTEIN. Good afternoon. I'm pleased to be here today to discuss the medicare home health benefit, and, in particular, the intermittent care requirement and its administration.

With me today are Martin Kappert, Acting Associate Administrator for Operations, and Robert Strimer, Deputy Director of the Bureau of Eligibility, Reimbursement and Coverage.

Whenever we talk about any aspect of the medicare home health benefit, we must keep in mind that this benefit has been growing rapidly in terms of both utilization and expenditures. Since the 1980 expansion in home health benefits, expenditures have doubled, the number of home health visits provided to medicare pa-

tients has grown 40 percent, and the number of participating home health agencies has grown 45 percent in just 3 years.

I know that the purpose of this hearing is to examine the intermittent care issue, and I will limit the rest of my remarks to that subject.

Frankly, Mr. Chairman, we are somewhat surprised at the amount of discussion the intermittent care requirement has engendered. Looking at our payments for home health care, we have found that less than 1 percent of the claims are denied for failure to meet coverage requirements such as intermittent and homebound.

And in discussions with the home health industry, concern has not focused so much on the limits of home daily care, but on the application of the intermittent guidelines by the intermediaries.

The issue is really one of flexibility versus specificity in the administration of the intermittent care requirement. Rigid guidelines could be used in promoting consistency, but they would be totally insensitive to individual patient needs.

Because of the intense interest and continuing debate on intermittent care, we initiated an open process to address the issues. Last September, the Administrator convened a meeting with representatives of national home health agency organizations and congressional committee staffs to discuss their concerns. Comments from four of the five organizations, which I would be pleased to submit for the record, indicated that a change in the guidelines was not necessary. Three of the organizations recommended taking steps toward a more consistent application of the guidelines.

As a result of our discussions, we have provided additional guidance to our regional offices and intermediaries to use in making coverage decisions on intermittent care.

The guidance clarifies that additional daily care beyond the 2- to 3-week limit need not be for a fixed period of time, but should be dictated by the medical needs of the beneficiary. We believe this approach makes clear that routine denial of care after 3 weeks or some other fixed period of time is not acceptable when such care is time-limited and justified with adequate medical documentation. And, also, that it preserves the intermediary's flexibility to apply judgments based on individual patient needs without the restrictions that rigid guidelines may have caused.

In addition to this clarifying guidance, we have taken other steps to provide for a more uniform application of the intermittent and other home health requirements. We, too, have been considering a reduction in the number of intermediaries in order to promote greater consistency in the administration of the home health benefit. And we understand that is now part of the language in the Deficit Reduction Act of 1984 as of last night.

We support the reconciliation conference recommendation to reduce to 10 the number of intermediaries. We have also developed a minimum data set to streamline reporting and integrate the physician's certification of need with the plan of treatment. This minimum data set should do much to promote consistent determinations. And we are increasing our compliance oversight of home health agency operations in response to concerns by GAO and

others that the home health benefit is being used to provide unnecessary care.

The medicare home health benefit is very complex, as the issues surrounding the administration of the intermittent requirements so well illustrate. We appreciate the input we have received from you and your staff on the intermittent care issue. The additional guidance we have provided will hopefully resolve current concerns about intermittent care without negative cost consequences to the program.

We need to work together to assure that the program will meet the needs of the beneficiaries.

And with that, we would be pleased to answer your questions.

[The prepared statement of Ms. Feinstein follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

PATRICE HIRSCH FEINSTEIN

ASSOCIATE ADMINISTRATOR FOR POLICY

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JUNE 22, 1984

Introduction

I am very pleased to be here today to discuss the Medicare home health benefit and in particular the intermittent care requirement and its administration. With me today are Mr. Martin Kappert, Associate Administrator for Operations and Mr. Robert Streimer, Deputy Director of our Bureau of Eligibility, Reimbursement and Coverage.

In the past year, there has been much discussion about whether Medicare home health benefits are being restricted through the application of the intermittent care requirement. Specifically, the controversy has centered on the amount of daily care that should be allowed under the requirement that care be provided on an intermittent basis.

In examining intermittent care, we found that the issue is two-fold: first, Medicare intermediaries are vested with the responsibility of determining necessary and appropriate coverage for all Medicare services and, consequently, guidelines are applied with flexibility across the nation, resulting in differing amounts of daily care being covered. Second, many home health advocates would like to see

THE INTERMITTENT CARE GUIDELINES AMENDED TO PERMIT MORE DAILY CARE.

OVER THE PAST SEVERAL MONTHS, WE HAVE BEEN REVIEWING VARIOUS MEANS OF RESOLVING THESE PROBLEMS. HOWEVER, BEFORE I DISCUSS THE INTERMITTENT CARE ISSUE, I WOULD LIKE TO DESCRIBE THE MEDICARE HOME HEALTH BENEFIT AND ITS GROWTH OVER THE YEARS.

THE MEDICARE HOME HEALTH BENEFIT

MEDICARE, AS ORIGINALLY ENACTED, IS AN ACUTE CARE PROGRAM WITH SERVICES DESIGNED TO SUPPORT THIS CONCEPT. CONSISTENT WITH THIS CONCEPT, MEDICARE'S HOME HEALTH BENEFITS ARE ORIENTED TOWARD A NEED FOR SKILLED CARE; THE BENEFITS WERE DESIGNED TO BE PART OF THE CONTINUUM OF CARE IN AN ACUTE EPISODE, EITHER FOLLOWING HOSPITAL OR NURSING HOME CARE OR AS AN ECONOMIC SUBSTITUTE FOR SUCH INSTITUTIONAL CARE.

UNDER THE MEDICARE HOME HEALTH BENEFIT, THE FOLLOWING TYPES OF SERVICES ARE COVERED:

- PART-TIME OR INTERMITTENT NURSING CARE PROVIDED BY OR UNDER THE SUPERVISION OF A REGISTERED PROFESSIONAL NURSE;

- PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY;

- MEDICAL SOCIAL SERVICES WHICH CONTRIBUTE SIGNIFICANTLY TO THE TREATMENT OF A PATIENT'S HEALTH CONDITION; THAT IS, SUCH SERVICES ARE NEEDED BECAUSE SOCIAL OR EMOTIONAL PROBLEMS IMPEDE THE MEDICAL TREATMENT;

- PART-TIME OR INTERMITTENT SERVICES FROM A HOME HEALTH AIDE; AND

- MEDICAL SUPPLIES (OTHER THAN DRUGS AND BIOLOGICALS) AND MEDICAL APPLIANCES.

THE MEDICARE LAW LIMITS PAYMENT FOR HOME HEALTH SERVICES TO THOSE BENEFICIARIES WHOSE CONDITIONS ARE OF SUCH SEVERITY THAT THE INDIVIDUALS ARE UNDER THE CARE OF A PHYSICIAN, CONFINED TO THEIR HOMES (HOMEBOUND) AND IN NEED OF SKILLED NURSING CARE ON AN INTERMITTENT BASIS OR PHYSICAL OR SPEECH THERAPY. THE CARE MUST BE PRESCRIBED BY A PHYSICIAN, AND THE SERVICES MUST BE PROVIDED BY A PARTICIPATING HOME HEALTH AGENCY (HHA) IN ACCORDANCE WITH THE PHYSICIAN'S TREATMENT PLAN. THE HOME HEALTH BENEFIT WAS DESIGNED TO PROVIDE HEALTH CARE TO PATIENTS WHO

CANNOT EASILY LEAVE THEIR HOMES. AN EXCEPTION IS MADE, HOWEVER, WHEN AN INDIVIDUAL REQUIRES MEDICAL SERVICES WHICH INVOLVE THE USE OF MEDICAL EQUIPMENT WHICH CANNOT READILY BE MADE AVAILABLE IN THE HOME.

EVEN THOUGH HOME HEALTH EXPENDITURES CONSTITUTE ONLY ABOUT 3 PERCENT OF OVERALL MEDICARE COSTS, THEY ARE GROWING RAPIDLY. FROM 1973 TO 1980 MEDICARE EXPENDITURES FOR HOME HEALTH CARE INCREASED AT AN AVERAGE ANNUAL RATE OF OVER 30 PERCENT. SINCE 1980, MEDICARE HOME HEALTH EXPENDITURES HAVE DOUBLED FROM $772 MILLION IN 1980 TO $1.5 BILLION IN 1983.

WHAT HAS CONTRIBUTED TO THESE EXPENDITURE INCREASES IN THE HOME HEALTH BENEFIT? THERE APPEAR TO BE SEVERAL UNDERLYING FACTORS WHICH WERE AMPLIFIED BY THE HOME HEALTH AMENDMENTS ENACTED IN 1980.

STUDY HAS FOUND THAT MUCH OF THE INCREASE, APPROXIMATELY TWO-THIRDS, IS DUE TO FACTORS OTHER THAN PRICE INFLATION. THESE FACTORS ARE:

- AN INCREASED PROPORTION OF BENEFICIARIES UTILIZING HEALTH SERVICES, WHICH ACCOUNTS FOR ALMOST HALF OF THE GROWTH IN EXPENDITURES,

- Increased visits per person served, which accounts for 8 percent of the growth in expenditures, and

- The growth in the number of Medicare beneficiaries, accounting for 10 percent of increased expenditures.

Passage of the Omnibus Reconciliation Act (P.L. 96-499) in 1980 expanded the home health benefit by removing the limit on the number of covered home health visits, eliminating the requirement for a prior hospital stay, eliminating the deductible and allowing more proprietary home health agencies to participate in the Medicare program. The premises behind these amendments were that the limits were arbitrary, that home health use could substitute for more expensive institutional care and that proprietary home health agencies were discriminated against by the statutory requirement that they must be licensed by the State in order to participate in Medicare. However, the effect of the amendments has been to foster a still more rapid increase in the utilization of home health services and in expenditures for those services. Since 1980, the

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ANNUAL NUMBER OF HOME HEALTH VISITS PROVIDED TO MEDICARE PATIENTS HAS GROWN BY 40 PERCENT, FROM 23 TO 37 MILLION VISITS A YEAR, AND EXPENDITURES, AS I MENTIONED EARLIER, HAVE DOUBLED.

ALONG WITH THE LEGISLATIVE CHANGES AND THE GROWTH IN HOME HEALTH USE, WE HAVE SEEN A CONCOMITANT GROWTH OF 45 PERCENT IN THE NUMBER OF PARTICIPATING HOME HEALTH AGENCIES, FROM 2,900 IN 1980 TO 4,200 BY THE END OF 1983. THE MAJOR PORTION OF THIS GROWTH HAS BEEN WITH PROPRIETARY HOME HEALTH AGENCIES, WHICH NOW NUMBER JUST OVER 1,200, UP FROM JUST UNDER 200 ONLY THREE YEARS AGO. THUS, THERE APPEARS TO BE A STRONG RELATIONSHIP BETWEEN SUPPLY AND DEMAND.

IT IS WITH THIS BACKGROUND OF INCREASING USE OF A RAPIDLY GROWING BENEFIT THAT WE COME TO THE INTERMITTENT CARE ISSUE.

INTERMITTENT CARE

THE LAW PROVIDES MEDICARE REIMBURSEMENT FOR REASONABLE AND NECESSARY HOME HEALTH NURSING AND AIDE SERVICES WHEN NEEDED ON AN INTERMITTENT BASIS. DAILY SKILLED NURSING AND AIDE SERVICES HAVE NEVER BEEN

CONSIDERED TO MEET THE STATUTORY REQUIREMENT OF INTERMITTENT NEED. DAILY AIDE OR NURSING SERVICES HAVE NEVER BEEN COVERED OVER AN EXTENDED TIME PERIOD AND GUIDELINES HAVE ALWAYS RESTRICTED COVERAGE OF DAILY CARE TO A SHORT PERIOD OF TIME TO CONFORM TO THE REQUIREMENT FOR INTERMITTENT CARE.

THE CURRENT GUIDELINES FOR APPLYING THE INTERMITTENT CARE REQUIREMENT SPECIFY, AND I QUOTE, "MEDICARE WILL PAY FOR PART-TIME . . . MEDICALLY REASONABLE AND NECESSARY SKILLED NURSING CARE 7 DAYS A WEEK FOR A SHORT PERIOD OF TIME (2 - 3 WEEKS)." THE GUIDELINES SPECIFY, HOWEVER, THAT CARE CAN EXTEND BEYOND THE THREE-WEEK PERIOD IF THE PHYSICIAN JUDGES THAT ADDITIONAL DAILY CARE IS NECESSARY AND THE HOME HEALTH AGENCY FORWARDS JUSTIFYING MEDICAL DOCUMENTATION TO THE INTERMEDIARY WITH AN ESTIMATE OF HOW MUCH LONGER DAILY SERVICES WILL BE REQUIRED. THE GUIDELINES ALSO STATE THAT PERSONS EXPECTED TO REQUIRE FULL-TIME SKILLED NURSING CARE OVER AN EXTENDED PERIOD OF TIME USUALLY WOULD NOT QUALIFY FOR HOME HEALTH BENEFITS.

THE CURRENT CONCERN ABOUT THE INTERMITTENT CARE REQUIREMENT IS REALLY ONE OF FLEXIBILITY VERSUS

SPECIFICITY IN ITS ADMINISTRATION. IT IS NOT DIFFICULT TO DEVELOP AND APPLY RIGID GUIDELINES THAT CONTROL THE EXACT AMOUNT OF HOME HEALTH CARE THAT CAN BE PROVIDED. SPECIFIC GUIDELINES REQUIRE LITTLE JUDGMENT, AND QUESTIONABLE CASES THAT MIGHT LATER BE SUBJECT TO APPEAL ARE VIRTUALLY ELIMINATED. HOWEVER, WE ALL KNOW THE PROBLEMS SUCH AN INFLEXIBLE SYSTEM CAN CREATE SINCE SUCH A SYSTEM WOULD BE TOTALLY INSENSITIVE TO UNIQUE PATIENT NEEDS AND VARIATIONS IN MEDICAL PRACTICE. RECOGNIZING THIS, THE MEDICARE PROGRAM HAS ALWAYS PROVIDED ITS FISCAL AGENTS DISCRETION TO BE RESPONSIVE TO LOCAL SITUATIONS AND INDIVIDUAL NEEDS. BUT THIS FLEXIBILITY ALSO PERMITS SOME VARIATIONS IN THE CONSISTENT AND UNIFORM APPLICATION OF THE INTERMITTENT REQUIREMENT. BECAUSE OF VARYING INTERPRETATIONS OF THE INTERMITTENT REQUIREMENT, PATIENTS MAY RECEIVE VARYING AMOUNTS OF DAILY CARE, DEPENDING ON THE INTERMEDIARY WHICH SERVES THEIR HOME HEALTH AGENCY. WE FOUND THAT THERE HAS BEEN AN UNEVENNESS IN THE APPLICATION OF GUIDELINES BY SOME INTERMEDIARIES BUT ALSO THERE HAS BEEN MISUSE OF THE BENEFIT BY SOME PROVIDERS. ALSO, SOME HHAS ARE FURNISHING <u>NEEDED</u> DAILY CARE, BUT ARE ONLY SELECTIVELY BILLING FOR THAT CARE; THAT IS, BILLING MEDICARE ONLY FOR CARE FURNISHED ON ALTERNATE

DAYS IN ORDER TO MEET THE INTERMITTENT CARE REQUIREMENT. IT APPEARS TO US THAT THE INTERMITTENT REQUIREMENT IS BEING CIRCUMVENTED, IN SOME INSTANCES, AS WELL AS NOT BEING MET.

THESE VARIATIONS IN THE COVERAGE OF DAILY CARE AND PROVIDER RESPONSES TO IT HAVE SPARKED INTENSE INTEREST AND CONTINUING DEBATE ON THIS ISSUE. LAST SUMMER, WE BEGAN RECEIVING MANY EXPRESSIONS OF CONCERN FROM CONGRESS, HOME HEALTH AGENCIES AND PATIENTS REGARDING THE APPLICATION OF THE INTERMITTENT CARE REQUIREMENT. IN RESPONSE TO THESE CONCERNS, THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION INITIATED AN OPEN PROCESS TO SEE IF THESE DIFFERENCES COULD BE RESOLVED. A MEETING WAS HELD LAST SEPTEMBER WITH REPRESENTATIVES FROM NATIONAL HOME HEALTH AGENCY ASSOCIATIONS AND CONGRESSIONAL COMMITTEE STAFFS TO DISCUSS THE ISSUE AND TO IDENTIFY REALISTIC PROPOSALS TO RESOLVE IT. THE ADMINISTRATOR ALSO REQUESTED THAT THE ASSOCIATIONS SUBMIT FURTHER COMMENTS AND SUGGESTIONS FOR POSSIBLE IMPROVEMENTS IN THE ADMINISTRATION OF THE INTERMITTENT CARE REQUIREMENT.

THE FIVE NATIONAL ASSOCIATIONS THAT WERE REPRESENTED AT THE MEETING -- THE NATIONAL ASSOCIATION FOR HOME

CARE, THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION, THE NATIONAL HOME CARING COUNCIL AND THE AMERICAN HOSPITAL ASSOCIATION -- ALL PROVIDED WRITTEN COMMENTS TO US. THREE OF THESE ORGANIZATIONS AGREED THAT THE GUIDELINES AND THE LIMIT ON DAILY CARE DID NOT NEED TO BE CHANGED BUT THAT STEPS SHOULD BE TAKEN TOWARD A MORE CONSISTENT APPLICATION OF THE CURRENT GUIDELINES BY THE INTERMEDIARIES. ONE ORGANIZATION FELT THAT INTERMEDIARY DENIALS OF DAILY CARE WERE NOT CAUSED BY UNCLEAR GUIDELINES, BUT RESULTED FROM EFFORTS TO ACHIEVE TARGETED PROGRAM SAVINGS THROUGH CLAIMS DENIALS. AND ONE ORGANIZATION ADVOCATED AN EXTENSION IN THE DURATION OF DAILY CARE TO SIX TO EIGHT WEEKS.

AS A RESULT OF THIS DIALOGUE, WE ISSUED CLARIFYING GUIDANCE FOR OUR REGIONAL OFFICES TO ASSIST INTERMEDIARIES IN MAKING MORE CONSISTENT INTERPRETATIONS OF THE INTERMITTENT REQUIREMENT. WE HAD FIRST CIRCULATED THIS MATERIAL TO THE INDIVIDUALS WHO HAD ATTENDED THE SEPTEMBER MEETING TO MAKE SURE THAT THE NEW GUIDANCE WOULD NOT CREATE PROBLEMS THAT WE HAD NOT FORESEEN.

THE NEW GUIDANCE CONTINUES TO SPECIFY THAT AFTER THE INITIAL 2 - 3 WEEKS, DAILY HOME HEALTH CARE IS AVAILABLE FOR A SHORT PERIOD OF TIME WHEN SUPPORTING MEDICAL JUSTIFICATION IS PROVIDED TO THE INTERMEDIARY. THE GUIDANCE GOES ON TO STATE THAT "THE AMOUNT OF ADDITIONAL DAILY CARE NEED NOT BE FOR A FIXED PERIOD OF TIME, BUT SHOULD BE DICTATED BY THE MEDICAL NEED OF THE BENEFICIARY." HOWEVER, THE GUIDANCE ALSO SPECIFIES THAT "DAILY SKILLED NURSING CARE OF AN INDEFINITE DURATION WILL NOT BE CONSIDERED TO MEET THE INTERMITTENT REQUIREMENT AND SUCH SERVICES ARE NOT COVERED UNDER THE MEDICARE HOME HEALTH BENEFIT." HOME HEALTH AGENCIES ARE ENCOURAGED TO FURNISH DOCUMENTATION SUBMITTED BY THE PATIENT'S ATTENDING PHYSICIAN IN ADDITION TO THE MINIMUM DATA ELEMENTS USUALLY SUBMITTED, AND INTERMEDIARIES MAY REQUEST ADDITIONAL DOCUMENTATION FROM BOTH THE HOME HEALTH AGENCY AND THE ATTENDING PHYSICIAN, IF NECESSARY.

WE BELIEVE THIS ADDITIONAL GUIDANCE MAKES ABSOLUTELY CLEAR THAT THE PATIENT'S CONDITION IS THE DECIDING FACTOR IN DETERMINING THE NEED FOR DAILY CARE BEYOND THE THREE-WEEK LIMIT. ROUTINE DENIAL OF DAILY CARE AFTER THREE WEEKS IS NOT ACCEPTABLE AS LONG AS

ADEQUATE MEDICAL DOCUMENTATION HAS BEEN RECEIVED BY THE INTERMEDIARY AND THE PATIENT'S NEED FOR SUCH CARE IS CLEARLY TIME-LIMITED.

WE BELIEVE THIS APPROACH TO RESOLVING THE INTERMITTENT CARE ISSUE PRESERVES THE INTERMEDIARIES' ABILITY TO CONSIDER INDIVIDUAL PATIENT'S CONDITIONS AND MAKES CLEAR THAT DENIALS CANNOT BE UNIFORMLY MADE FOR ALL CARE BEYOND A PREDETERMINED, FIXED PERIOD OF TIME.

THE ADDITIONAL GUIDANCE WE HAVE PROVIDED TO OUR REGIONAL OFFICES FOR THE ADMINISTRATION OF THE HOME HEALTH INTERMITTENT CARE REQUIREMENT WAS DEVELOPED IN AN OPEN MANNER THAT WILL LEAD, HOPEFULLY, TO A SATISFACTORY RESOLUTION OF CURRENT CONCERNS WITHOUT NEGATIVE COST CONSEQUENCES TO THE PROGRAM.

OTHER HOME HEALTH EFFORTS

BEFORE CONCLUDING MY STATEMENT, I WOULD LIKE TO TOUCH ON SOME ADDITIONAL WORK WE ARE DOING TO EXAMINE ALTERNATIVE PAYMENT METHODS FOR HOME HEALTH CARE.

Prospective Payment for Home Agencies

Earlier this year we awarded a contract for the development of a prospective payment demonstration for home health agencies. The objective of this demonstration is to test the effect of various prospective payment methodologies on expenditures, the quality of care and the operations of home health agencies. The contractor is currently in the design phase during which the specific payment methodologies will be examined, a process to monitor the quality of care provided will be developed, a data collection system will be designed and home health agencies will be selected and trained to participate in the demonstration.

We expect that the experimental phase of this demonstration, during which actual payment mechanisms will be tested, will begin next spring in about five locations and will continue for three years while data is collected to evaluate the project.

Competitive Bidding for Home Health Services

Within the next few months, we also plan to award a contract to develop competitive bidding models for

PURCHASING HOME HEALTH SERVICES. THE COMPETITIVE BIDDING MODELS WILL BE DESIGNED TO USE THE MARKETPLACE TO ENCOURAGE THE EFFICIENT DELIVERY OF HOME HEALTH SERVICES AT THE LOWEST AVAILABLE PRICES, WITH NO LOSS IN QUALITY. THE CONTRACTOR WILL EXAMINE SUCH ISSUES AS THE USE AND SCOPE OF THE BIDDING SYSTEM, THE DANGER OF MONOPOLISTIC EFFECTS, THE UNITS OF REIMBURSEMENT AND THE BID AND PRICE SELECTION METHODS AND WILL PRESENT US WITH SEVERAL MODELS FOR COMPETITIVE BIDDING. WE PLAN TO SELECT THREE OR MORE MODELS FOR FURTHER DEVELOPMENT AND POSSIBLE TESTING.

CONCLUSION

THE MEDICARE HOME HEALTH BENEFIT IS VERY COMPLEX AND THE ISSUES SURROUNDING THE ADMINISTRATION OF THE INTERMITTENT REQUIREMENT ILLUSTRATE WELL THIS POINT. THESE ISSUES HAVE RAISED QUESTIONS NOT ONLY ABOUT THE BEST ADMINISTRATIVE APPROACHES, BUT ALSO ABOUT THE NATURE OF THE BENEFIT ITSELF.

WHILE IT IS PROBABLY TRUE THAT HOME CARE IS LESS EXPENSIVE THAN INSTITUTIONAL CARE WHEN SUBSTITUTED ON A ONE-TO-ONE BASIS, WE HAVE FOUND THAT THIS IS RARELY THE CASE. STUDIES PERFORMED BY HCFA AND THE GENERAL

ACCOUNTING OFFICE HAVE FOUND THAT EXPANDED HOME CARE DOES NOT SUBSTITUTE FOR INSTITUTIONAL CARE UNLESS INDIVIDUALS AT RISK FOR SUCH CARE ARE VERY CAREFULLY TARGETED TO RECEIVE ALTERNATE SERVICES IN THE HOME. WE HAVE ALSO FOUND THAT IT IS VERY DIFFICULT TO PREDICT EXACTLY WHO WOULD ENTER AN INSTITUTION AND SHOULD THEREFORE BE THE MOST COST-EFFECTIVE UTILIZER OF HOME CARE. WE ARE NOW PERFORMING ADDITIONAL STUDIES TO DETERMINE IF WE CAN IMPROVE THIS TARGETING. WITHOUT IMPROVED TARGETING, EXPANDING THE HOME HEALTH SERVICES AVAILABLE COULD SIMPLY LEAD TO INCREASED UTILIZATION OF HOME HEALTH SERVICES WITHOUT DECREASING THE USE OF INSTITUTIONS, LEADING TO EVEN GREATER OVERALL EXPENDITURES.

I THINK YOU WOULD AGREE THAT ANY CHANGES WE MAKE IN THE MEDICARE HOME HEALTH BENEFIT MUST BE CAREFULLY EXAMINED FOR THEIR COST IMPLICATIONS, PARTICULARLY AT A TIME WHEN THE MEDICARE HEALTH INSURANCE TRUST FUND IS IN JEOPARDY.

WE APPRECIATE THE INPUT WE HAVE RECEIVED FROM YOU AND YOUR STAFF ON THIS ISSUE. WE NEED TO CONTINUE OUR WORK TOGETHER TO ASSURE THAT THE MEDICARE PROGRAM MEETS THE HEALTH CARE NEEDS OF THE BENEFICIARIES.

Senator DURENBERGER. I thank you for the statement. The statement says there really was no reason to have this hearing. That everybody that comes after you is blowing smoke. I am tempted to suggest, since it's Friday afternoon, and nobody has anything to do that maybe you and or one of those folks can just slide down to the end of the witness table and we will bring up the next panel and maybe hear from them, and then you could respond.

I do have some questions that I have been provided which says, for example, why is the definition of intermittent been put only in guidelines, not in regulation? And I think you may have answered that already.

Ms. FEINSTEIN. Well, we had begun with an open mind that maybe we did need to go through an entire redefinition of intermittent. But our process with the industry and congressional staff, and the like suggested to us that our definition was just fine the way it was, and that the problem was better administration of the benefit and not the definition of the benefit. So we issued clarifying guidance to our intermediaries about those grey areas that some folks had some concern about.

Senator DURENBERGER. Can you tell me what is the incentive, disincentive situation with regard to the intermediaries? It sounds like one of those situations where you have tried to delegate a certain amount of discretion to intermediaries because you don't want arbitrariness in the system. I have to assume that the next five witnesses or most of the five, I guess, must be having some problems with the way some intermediaries are interpreting this discretion.

Does the intermediary have some financial or other incentive to sort of tighten up and not be too discretionary in what they do? How does that process work?

Ms. FEINSTEIN. Well, the intermediaries are scored on the administration of this benefit the same as they are in any of the other benefits. But I think when you abstract from that and look at the actual number of claims denied, bills denied in home health versus other benefits, you find that home health is the lowest level of total bills denied. And when you look even further, you find that the number of bills denied because of reasons having to do with intermittent and homebound is less than half of 1 percent of all the bills, the lowest in the history of the program. So I'm a little confused as to what all the excitement is about.

Senator DURENBERGER. If you have to do something for the next hour and a half, can you leave somebody behind so that I can get a response as soon as these other witnesses are through? I guess the tradition around this place is that if you are from the Government, you go first, and the people have to come second. And it has always bothered me, but that's apparently the rules and they preceded Bob Dole. So I would love to have somebody from the Government just stay around, maybe take a side seat, and we will let the next panel come up. And when they get all through, I'm just going to ask somebody to respond.

Ms. FEINSTEIN. That's fine.

Senator DURENBERGER. I don't want to put you in the position of having to do that, but maybe you can delegate one of these gentlemen to do it.

Ms. FEINSTEIN. All right.

Senator DURENBERGER. Are you going to flip a coin or are you all going to stay?

Now I have just had explained to me that we have a seating problem. We have got five panelists and some accompanyists. And it would really help if the accompanyists sat in the second row rather than the first row and then I won't get confused as to who is Ms. Mary Suther, chief executive officer of the Visiting Nurse Association of Dallas. Who is Mary? OK.

And then Ms. Margie Mills, executive administrator and director of the medical services for ABC Home Health Services, Brunswick, GA; Ms. Rosemary Bowman, president of Health Care Partners, Nashville; and Ms. Eddie Bernice Johnson, executive officer, community relations and development, Visiting Nurses Association of Texas.

Now I have got some accompanyists up here who didn't hear what I said. If you really wouldn't mind occupying a chair back there, I want to leave a little room.

We have a number of people from Texas here. And their Senator, who is a member of this committee, is totally bogged down in that conference bill. Lloyd Bentsen would loved to have been here, I imagine, to introduce and say nice things about you all. I see the statement here on your behalf by Senator Bentsen. And I will just place it in the record as though he had been here.

And we will ask Mary Suther to be the first to testify. All of your statements will be made part of the record, by the way.

STATEMENT OF MARY SUTHER, CHIEF EXECUTIVE OFFICER OF THE VISITING NURSE ASSOCIATION OF DALLAS, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE AND THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION, WASHINGTON, DC

Ms. SUTHER. Mr. Chairman, and members of the committee, I appreciate the opportunity to testify before this group. My name is Mary Suther. I am the chief executive officer of the Visiting Nurse Association of Texas. I also serve on the Governmental Affairs Committee of the National Association for Home Care, the Nation's largest organization representing providers of home care and hospice care and health care professionals.

Here with me today is Edward Lenz, of the Home Health Services and Staffing Association, which represents taxpaying investor owned home health and temporary staffing organizations, with over a thousand offices in 44 States.

As spokespersons for the home care industry, we are particularly concerned that the existing benefit is being unjustifiedly limited, contrary to congressional intent, by HCFA, and its contract intermediaries. The intermittent care issue is of particular importance because it determines the nature and frequency of the home care benefit to nearly 2 million elderly and disabled people who are supposedly beneficiaries.

The benefit is not being administered on a uniform basis. Instead of need, cost effectiveness or the statute being the basis for admin-

istration, where a beneficiary lives is more nearly what determines the service received the beneficiary.

In creating the benefit, Congress stated that care was to be intermittent, but did not define what constituted intermittent care. HCFA never promulgated regulations for public comment in the Federal Register which would define limits of intermittent care. HCFA issued guidelines to the intermediaries stating that intermittent care would be 7 days a week for 2 to 3 weeks, and thereafter under unusual circumstances.

The problem is medicare is a national benefit. Beneficiaries living in California may receive services somewhat different or greatly different from those living in Wisconsin. I have worked in 13 States, and I have worked under many intermediaries, and there is no rhyme or reason as to the difference in the benefits. I thought I knew home care, but I find everytime I move, I don't. I have been in the business 25 years.

Some define intermittent care as 7 days a week, some 5 days a week and some 3 days a week. That is daily, they say. I hope I don't have to use that definition to define when I receive my daily bread.

Some say that the cutoffs are 2 to 3 weeks with extensions as necessary. Others say that those are the caps and cannot extend it beyond 2 or 3 weeks. We recently are being hard pressed to even receive 1 week of daily care for our patients. Regardless of what the physician and acceptable medical practice in the community is, there are literally thousands of cases where patients have been authorized by the physician to receive care but denied the care by intermediaries, many of whom had to go into the hospital, some of whom were on waiting lists to get a hospital or nursing home bed. Incidentally, some of those cases—the intermediary determined that they were too sick for home health care and denied it, saying they should be in the hospital, in spite of the fact that they couldn't get a bed.

With prospective reimbursement, patients are being discharged quicker and sicker, as predicated by the GAO 1983 report and a New Jersey experience. It is imperative that the benefit be administered rationally and consistently. A liberalized standard definition needs to be legislated because HCFA will not respond satisfactorily, and beneficiaries are not being treated consistently.

That is why we have turned to Congress for assistance. Congressman Henry Waxman and Senators John Heinz and Lloyd Bentsen introduced legislation to clarify the definition of intermittent care, H.R. 3616, which provides for up to 90 days of care with physician certification; and S. 2338, which provides for up to 60 days of care with physician certification.

No action was taken. And as you know, this was referred to the conferees on the Omnibus Deficit Reduction Act. I will comment on what has happened with that later.

Regardless of what has happened with that, it would at best have been a band-aid approach.

What we need is a guarantee of number of days. It needs to be applicable to all beneficiaries regardless of referral source instead of only those that are hospitalized. That's why this hearing is so important.

The benefit was created to meet unmet medical needs of elderly and disabled. The intent was clearly conveyed in the pivotal statutory requirement that a physician must certify that the patient needs the home care, that it is reasonable, that it's necessary and that the patient is homebound in lieu of institutional care.

Despite this clear mandate, no critical basis has ever been established to denote the duration of the care to be given. Only arbitrary guidelines and very arbitrary at that.

On May 28, 1983, the National Association for Home Care requested that HCFA create an expert panel to review the feasibility of establishing such a clinical basis. HCFA never responded. We have presented mounds of evidence of specific procedure, diagnoses, and symptoms which require 45 days or more of daily care, such as purulent draining wounds. I think some of my cohorts have pictures of such wounds.

Without such a clinical basis for a definition, the definition might just as well have been pulled from Webster's Dictionary. It's my understanding that one of the administrative law judges that had overturned some of the decisions of HCFA said just that. That even Webster's Dictionary would not have prohibited the care of these patients on a daily basis.

Senator DURENBERGER. Are you getting near the end of your statement?

Ms. SUTHER. We have urged a Waxman-Heinz approach. We would be pleased to work with this committee in any way necessary. There are many, many other problems—homebound, skilled care, medical necessity reasonableness. If they deny care on the basis of one of these, and we appeal that, then they deny it on the basis of another, and you have to go through the entire costly process again, while the patient is left on a limb.

The associations that I represent implore you to develop a group of experts to develop some clinical basis for the establishment of these guidelines in the future.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Suther follows:]

STATEMENT OF MARY SUTHER, CHIEF EXECUTIVE OFFICER

VISITING NURSE ASSOCIATION OF DALLAS

on behalf of

NATIONAL ASSOCIATION FOR HOME CARE

HOME HEALTH SERVICES AND STAFFING ASSOCIATION

before the

COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
UNITED STATES SENATE

The Honorable Dave Durenburger
Chairman

Washington, D.C.

June 22, 1984

SUMMARY OF TESTIMONY OF MARY SUTHER, CHIEF EXECUTIVE OFFICER, VNA OF DALLAS, FOR THE NATIONAL ASSOCIATION FOR HOME CARE AND HOME HEALTH SERVICES AND STAFFING ASSOCIATION

(1) HCFA and its contract intermediaries are unjustifiably limiting the Medicare home health benefit by restrictive and inconsistent interpretations of "intermittent care."

(2) The implementation of the hospital prospective payment plan has exacerbated the "intermittent care" problem.

(3) The Senate provision of the Omnibus Deficit Reduction Act allowing for up to 45 days of daily care following hospitalization fails to deal with the problem of inconsistent definitions of intermittent care as applied to those Medicare beneficiaries who are admitted from referral sources other than hospitals.

(4) A clinical basis for "intermittent care" must be established to determine which procedures, symptoms, or diagnoses require daily visits and the duration of such visits.

37-568 O—84——3

Mr. Chairman and Members of the Committee:

My name is Mary Suther. I am the Chief Executive Officer of the Visiting Nurse Association of Dallas. I also serve on the Government Affairs Committee of the National Association for Home Care (NAHC). NAHC is the nation's largest organization representing home care and hospice providers and professionals. Our 2,000 + members include both non-profit and for-profit agencies, free-standing as well as hospital and other institution-based providers, major corporate chains, homemaker/home health aide agencies, and hospices.

Here with me today is Edward Lenz, Chairman of the Board of Home Health Services and Staffing Association (HHSSA), which represents 14 tax-paying, investor-owned home health and temporary staffing organizations that provide services through 1,000 offices in 44 states.

Our organizations together represent home care agencies of all types. Our members provide much of the home care and hospice services available in this country and have accumulated many years of experience with both government and private payment programs.

On behalf of these organizations and myself, I want to commend this Committee for holding this important hearing and for recognizing that there are significant problems with the administration of the home health benefit under the Medicare program.

As spokespersons for the home care industry, we are particularly concerned that the existing Medicare home health benefit is being unjustifiably limited, contrary to Congressional intent, by the Health Care Financing Administration (HCFA) and its contract intermediaries. This is being done by restrictive and inconsistent interpretations of the term "intermittent care" and other eligibility and coverage criteria as defined in the Medicare statute. The "intermittent care" issue is of particular importance because it determines the nature and frequency of home care to nearly 2 million elderly, infirm and disabled beneficiaries.

In creating the Medicare home health benefit, Congress stated that covered care was to be "intermittent" but did not specifically define what constituted "intermittent care". The Health Care Financing Administration never promulgated regulations for public comment in the Federal Register to define the limits of intermittent care. However, HCFA did issue guidelines on intermittent care to the fiscal intermediaries who process claims for home care providers (see Sections 204.1 and 206.6, Health Insurance Manual 11). Under these guidelines, intermittent care would include daily care (7 days a week) for a 2-3 week period, and thereafter under "unusual circumstances." The major problem with these guidelines is the varying and inconsistent interpretations by fiscal intermediaries as to what consititutes intermittent care. Although Medicare is a national benefit, a Medicare beneficiary living in Califorinia can receive a substantially greater benefit than one living in Wisconsin. Some intermediaries consider "daily" to mean 7 days a week, but others consider it to mean 5 or even as little as 3 days a week. Some intermediaries view the 2-3 week initial period as a guideline and consider extensions of this period on a case-by-case basis; others see 2-3 weeks as a rigid cut-off point, regardless of medical reasonableness and necessity as determined by a physician. One example of the many types of problems this has created is illustrated by a situation in Michigan. Two home health agencies operate in the same city within 5 miles of each other. Each is served by a different intermediary, because one of the agencies is a chain served by a central intermediary. One intermediary is liberal, the other restrictive. So, depending on which agency a patient uses, he/she will get more/less coverage.

The implications of these varying and inconsistent interpretations of "intermittent care" are that there are thousands of cases where patients who have been authorized by physician as medically needing home care have been denied home care outright, or have had home care severly limited. For example:

* A patient in Mississippi was discharged prematurely from the hospital, due to lack of hospital days covered. The patient's family was elderly, weak, uneducated and unable to handle adequately a bed patient weighing 300 pounds. No nursing bed was available at the patient's care level. She developed a skin breakdown on her buttocks prior to her discharge from the hospital and

required daily decubitis care. She also had an indwelling catheter requiring frequent irrigation. She required daily aide visits, but had to be decreased to 3 times a week because of the limited interpretations of intermittent care. Without this needed care, the patient expired at home.

* A patient in Georgia was discharged from the hospital with a temporary colostomy, a 6"-8" draining incision mid-abdomen and severe swelling of hands and legs. The physician ordered daily visits for ostomy irrigation and bag changes, sterile dressing changes, diet instruction and medication monitoring. There was no one in the patient's home who could learn any of this care. She had exhausted hospital days and could not afford nursing home placement or private duty nurses. She needed daily visits for 45 days until the physician could close the ostomy. The fiscal intermediary told the HHA this claim will be denied, as care is not "intermittent".

* A 76-year-old patient in North Carolina with severe cellulitis of both legs was discharged by the hospital because she had received services for a period considerably longer than DRG reimbursement indicated is normal. The hospital requested admission to home health services, for treatment by an RN three times per day for administration of IV antibotic. The fiscal intermediary, upon learning that this treatment would run 3-4 weeks, stated that this care would exceed their interpretation of "intermittent". The patient was required to transfer to a local nursing home. The nursing home had little experience with IV therapy and was unable to start an IV line on the patient, so they shifted her to daily intramuscular injections. She is responding very poorly to this therapy regimen. It is likely that she will lose her leg.

* An eighty-year old patient in New Mexico had 16 open draining wounds. His daughter, an alcoholic, would not feed her father when the home staff was not present. Because the wounds did not respond to treatment by the home health agency within 21 days -- the intermediary's limit on daily care -- the patient was hospitalized. Cost per month of home health care was $1,527 including supplies and visits. Cost of a hospital stay for six weeks was over $8,000 paid for by Medicare.

With the implementation of the hospital prospective payment plan (DRGs), the already acute "intermittent care" problem will be exacerbated. All the leading spokespersons on this issue have predicted that patients will be released from hospitals more quickly and in a sicker condition. For example, Terry Leggett, Vice President of Finance at Valley Presbyterian Hospital (Van Nuys, CA), is one of the many health care practitioners experiencing the new DRG system. In a June 1984 article in Modern Healthcare magazine Mr. Leggett observed, his hospital is "about 15% ahead of the game (compared to revenue it would have have received under the cost-based reimbursement system)." Medicare length of stay in his hospital dropped 24% (from 8.39 days to 6.37 days) in the first 6 months of FY '84 compared to FY '83. And, he noted, "Medicare patients are being discharged a lot sooner and sent home sicker. As a result, we're doing pretty well on prospective payments."

In addition, a November 1983 GAO report (IPE 84-1) states it is likely that DRGs will exacerbate the number of Medicaid patients in hospitals awaiting nursing home or home care placement. And evidence from New Jersey, where the model for the Medicare DRG system has been in operation for 3 years, indicates the DRG system financially benefits hospitals and results in more patients with more severe conditions going to home care agencies which, in turn, must increase their staff, hours, and high tech nursing services.

Since the burden of caring for these sicker patients is likely to fall more and more on home care providers, a more reasonable standard definition of intermittent care is critical. If at best these new sicker patients can only receive 2-3 weeks of daily care under the Medicare benefit, many patients will be falling between the cracks -- too sick for home care, but not sick enough for

nursing home eligibility. The result easily could be an increase in hospital admissions and re-admissions -- something which will defeat the cost containment goal of the DRGs -- or thousands of elderly going without necessary care.

The National Association for Home Care wrote to HCFA as early as May 28, 1983, extensively outlining the problem regarding varying and restrictive definitions of "intermittent care". Having received no satisfactory response from HCFA, NAHC turned to Congress for assistance. To help resolve the problem, Congressman Henry Waxman and Senators John Heinz and Lloyd Bentsen introduced legislation to clarify the definition of what constitutes "intermittent care" under the Medicare home health benefit. The Waxman bill (H.R. 3616) would define intermittent care to include up to 90 days of daily care by a nurse or home health aide with monthly physician certification that care is reasonable and necessary. The Heinz/Bentsen bill (S. 2338) parallels the Waxman bill, but provides for 60 rather than 90, days of daily care. Although both bills gathered numerous co-sponsors, no action was taken on either. The matter is now before the conferees on the Omnibus Deficit Reduction Act. The conferees are deciding whether to include a Senate provision which would define "intermittent care" to include up to 45 days of daily care following hospitalization. Although this provision helps to respond to the emergency situation created by the implementation of the hospital DRG system, it fails to deal with the general problem of inconsistent definitions of intermittent care as applied to those Medicare beneficiaries who are admitted from referral sources other than hospitals.

The problem of Medicare beneficiaries referred to home care from non-hospital sources is significant. It must be dealt with. First, there are significant numbers of these people. The preliminary results of NAHC's 1983 national home care survey indicate that in 1982, about 53 percent of all persons referred to home care agencies were referred from non-hospital sources. Second, Bureau of the Census data indicates that as the elderly (over 65) population continues to increase, so does the proportion of that population which is over 85 years of age. And data from the Urban Institute and National Center for Health Statistics indicates that persons over 85 years of age have more multiple and severe diagnoses requiring more prolonged skilled care, but not necessarily requiring hospitalization.

It's quite simple. As a general rule the older you get, the sicker you become, and the more health care you require. NAHC's 1983 survey shows that as of 1982, over 12 percent of all persons receiving home care were 85 years or older while only slightly over 1 percent of the nation's aged populations is 85 years or older!

The extent of the non-hospital referral source cannot be over-estimated. As an advocate of capitated alternate health care systems, Mr. Chairman, I'm sure you are aware of the rapid growth of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Competitive Medical Plans (CMPs). You have encouraged such ventures -- and rightly so. The growth of these entities provides another reason for the increased use of home care and for the increase of non-hospital referral sources. When combined with the growing involvement of physicians in non-hospital health care ventures, we see an increased need for having to deal with persons from non-hospital referral sources who often require more intensive skilled care than has been traditionally demanded from home health agencies.

Regardless of how the Conferees act on the 45-day post-hospital home health proposal, the remedy will only be a band-aid approach unless a provision is adopted which:

(a) provides an adequate guaranteed number of days of daily care to deal with the numerous single and multiple diagnoses and procedures which require extensive daily home care, but do not require institutional care, and

(b) makes the daily care coverage applicable to all Medicare beneficiaries regardless of their referral source.

That is why this hearing is important.

In a certain way, we are not surprised that HCFA and its contract intermediaries are having so much difficulty interpreting what consititutes intermittent care. The legislative history surrounding the Medicare home health benefit indicates that this benefit was created to meet previously unmet medical needs of the elderly and disabled. This intent was clearly conveyed in the pivotal statutory

requirement being physician certification of the "medical necessity and reasonableness" of the need for home health care as opposed to institutional care. Despite this clear mandate, no clinical basis has ever been established to determine the duration of care needed. When HCFA established 2-3 weeks of daily care as a guideline for "intermittent care", it was arbitrarily selecting a time period, with no clinical basis.

What is urgently needed is just such a clinical basis to determine which procedures, symptoms, or diagnoses require daily visits and the duration of such visits. NAHC's May 20, 1983 letter to HCFA suggested the creation of an expert panel to review the feasibility of developing such a clinical basis. HCFA never responded. In our talks with HCFA and Congress, we have presented mounds of evidence of specific procedures, diagnoses and symptoms which require 45 days or more of daily care. And yet the current guideline still contains no clinical guidance on regular or "unusual circumstance" criteria to give presumptive coverage to cases involving certain specific situations which clinically require daily care short of hospitalization. Without such a clinically-based definition of "intermittent care" the definition of "intermittent care" might just as well be pulled from Webster's dictionary. (I would note parenthetically that at least one of the dozen or so Administrative Law Judges who have reversed intermediary claims denials based on restrictive interpretations of "intermittent care" noted that even the dictionary definition of "intermittent" clearly would allow daily care for more than 2-3 weeks.)

It is clear that some modifications are required to ensure that Medicare beneficiaries receive the home care to which they are entitled and which Congress clearly intended them to have. We have urged a Waxman or a Heinz/Bentsen approach -- establishing a specific number of days for daily care at a more appropriate level -- because of the variation from jurisdiction to jurisdiction, and because specific "guideline" figures for allowable days tend to become ceilings for daily care, as applied by intermediaries. We do feel that a more logical long-term approach would be to convene a panel of experts to come up with a clinical basis for determining duration of care. Our Association would be pleased to work with the Committee on this issue.

I have focused on "intermittent care" because of its significance and because it is the area of Medicare home health coverage most affected by DRGs. However, I

would be remiss if I did not at least mention briefly that we have other and numerous problems with intermediaries on the interpretation of other eligibility and coverage terms such as "homebound", "skilled nursing", and "medical necessity and reasonableness." This is particularly troublesome because often medical judgments on what is "skilled nursing" and "medical necessity" are made by reviewers of the intermediary who have little or no knowledge of the area they are reviewing.

This occurs in many instances because HCFA does not require the intermediaries to meet minimum professional standards as to who they employ to review cases involving nursing, speech, physical, or occupational therapy care. They don't even require that a physician must review the physician certifications. One of the more flagrant examples of inappropriate medical review staff is one intermediary whose medical director, in charge of reviewing physician (M.D.) certification of medical necessity for home health, is a dentist. Home Health does not cover dental care! And there are numerous instances where nurses, without any home care or therapy background, are not only used to review home care nursing visits but also speech, physical, occupational therapy and medical social work visits.

We find this most disconcerting and ironic since, in order to render care, the Medicare regulations require all nurses, therapists, medical social workers, and certifying physicians to meet specific professional criteria if we are to receive Medicare certification. All we ask is that the same criteria be applied to intermediary personnel who review claims for such care. We would urge you to look into this issue and also, at least in the interim, the feasibility of some PRO-type review of at least "medical necessity and reasonableness." Such a system would provide an outside, objective entity with trained medical staff to review medical issues instead of the intermediary.

I wish to close my testimony by submitting for your review, and for the record, NAHC's 1984 Legislative and Regulatory Agenda. It outlines the intermittent care and other issues I've referred to today, as well as numerous others.

This concludes my testimony. I would be pleased to answer any questions you might have.

Senator DURENBERGER. Before our next witness begins, let me just say what I should have said earlier. That we do make your statements part of the record, and we ask you to summarize them in 5 minutes. And I would just ask each of the rest of the witnesses, to try to be as specific as you can about specific problems. I think our first witness, at least for me, has built sort of a framework in a general sense of the problems so that the rest of you can be very helpful if you can add a degree of specificity to the problems.

The next is Ms. Margie Mills.

STATEMENT OF MARGIE MILLS, EXECUTIVE ADMINISTRATOR AND DIRECTOR OF MEDICAL SERVICES, ABC HOME HEALTH SERVICES, BRUNSWICK, GA, ON BEHALF OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, WASHINGTON, DC

Ms. MILLS. Mr. Chairman, my name is Margie Mills, and I'm executive administrator and director of Medical Services for ABC Home Health in Georgia. I have been in the business since 1976. And I and Ms. Suther have seen many changes in the interpretations of regulations, but very few changes in the actual regs. Just changes that the intermediaries make in the interpretation.

I am also a member of the Board of Directors of American Federation of Home Health Agencies, which I represent here today.

Many elderly and disabled Americans are being denied their right to home care simply because of where they live. If they live in New York City, they can get three visits a day over an extended period of time. If they live in the State of Georgia, they cannot receive more than 2 weeks of daily visits.

And this is a problem with the medicare program.

Senator DURENBERGER. Two weeks of once a day versus three times a day in New York?

Ms. MILLS. That's right.

Senator DURENBERGER. Without a limitation?

Ms. MILLS. That's right.

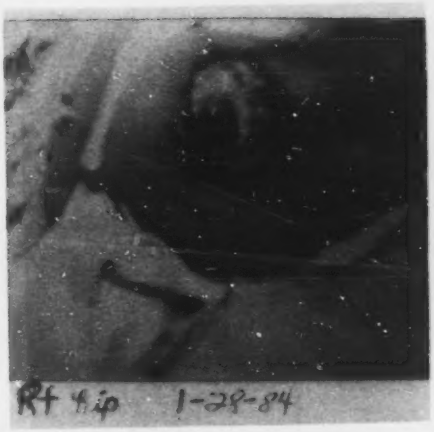
Our written testimony today will give background of this problem. But in the short time I have, I would like to illustrate the inconsistent and arbitrary way that the current policy is being administered.

A visiting nurse association in the Southwest was denied all visits to an 80-year-old alzheimers disease victim for March and April after being reimbursed for daily visits in previous months. Then the intermediary turned around after denying these 2 months, and paid for 2 additional months of daily visits, which there is no consistency at all in those types of decisions.

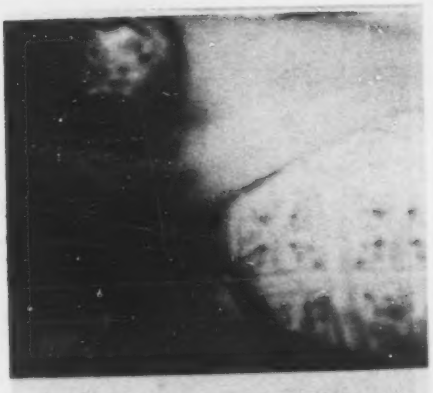
This patient had the ulcers. I have the pictures here to show where the patient came from and where he is today. But there was no consistency in that they would pay for 2 months and then the next 2 months they deny it.

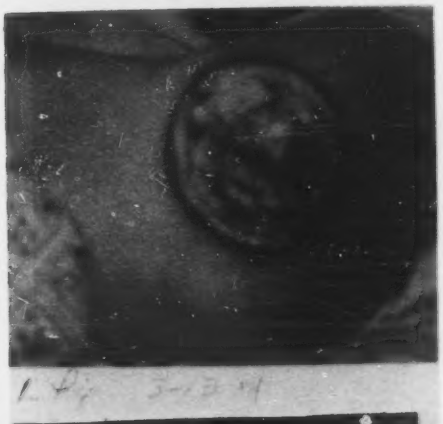
I would like to enter these pictures in with our testimony in the record.

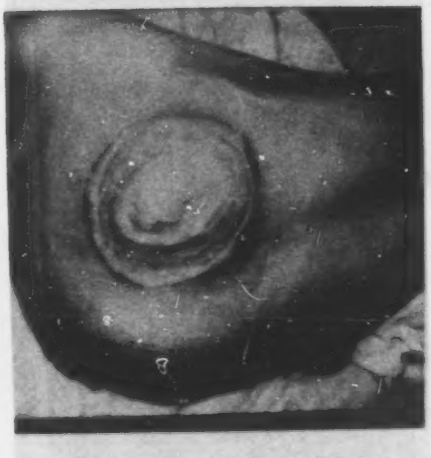
[The pictures from Ms. Mills follow:]


Rt hip 1-28-84

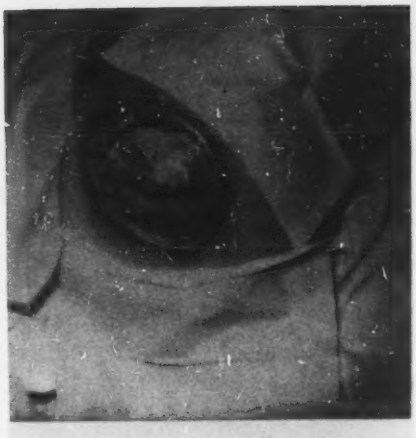
Lt hip 1-28-84




Lt hip 3-30-84


Rt hip 3/30/84

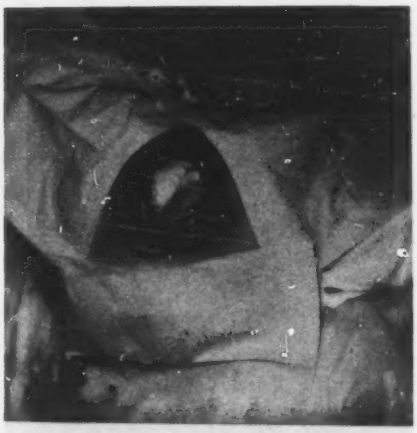
Lt hip 3/30/84



Left hip 3/30/84

Lt. Hip

5/21/84



Rt hip 3/30/84

Rt Hip

3/30/84

Ms. MILLS. You cannot look at these photos and not see that this man had the need for the daily visits; and the physicial intermediary looked at the pictures and denied the visits anyway.

In our own agency, we treated a 67-year-old woman with one rectal and four abdominal abscesses, a draining 7-inch abdominal incision and an ostomy. Her physician ordered daily skilled nursing visits to perform ostomy irrigations in directing changes. Our intermediary questioned whether the daily visits to this beneficiary are necessary, and has referred this case to the regional office. And we are still waiting an opinion.

We could treat that patient successfully for approximately $1,200 a month. A bed alone in the nearby hospital would have cost medicare $4,500 for that same month. And there is not a single skilled nursing facility in the whole area that would accept this patient. All the nursing homes in the area where she lived were intermediate care facilities and refused admission to this patient.

Our agency is also treating a young man on medicare disability, a spinabiffida patient with a draining abscess in the buttocks area. He needs daily packing and dressing of his wound. But we were forced to reduce his visits after 2 weeks of daily visits to three times a week. Instead of being able to heal his wound in 2 months, we are still seeing this patient 1 year later three times a week and our intermediary is paying for these. And he still needs the service.

Mr. Chairman, we understand that action was taken yesterday by Senate and House conferees. Although preliminary records indicate nothing pertaining to intermediate care was included in the legislation, it is our understanding that the conference report will include language directing HCFA and its physical intermediaries to follow its own current policy of 2 to 3 weeks of daily skilled nursing visits, and beyond that with physician certification of need.

We believe inclusion of such language is a big step in the right direction. As we have seen, physicial intermediaries are not adhering to the current policy, and HCFA has not attempted to ensure that they are followed. It is going to take a change in attitude on the part of HCFA and the intermediaries to make sure it is followed.

We urge the appropriate congressional committees to exercise careful oversight to make sure that the intermittent care policy is being applied in a consistent manner and that medicare beneficiaries are receiving the home health services they require and that they are entitled to.

I also have a couple of letters from physicians to submit that they have written on behalf of the intermittent care issue.

[The letters and prepared written statment from Ms. Mills follow:]

R. A. Acree, M.D., P.C.
P. O. Box 856

R. T. Morgan, M.D., P.C.
P. O. Box 672

901 North Parrish Avenue
Adel, Georgia 31620

Phone [912] 896 7448
Phone [912] 244 3360

March 2, 1984

Blue Cross Blue Shield
P.O. Box 7368
Columbus, GA 31908

Re: Ronald Wilkes
256-26-8369-C2

To Whom it May Concern:

I have learned that some home nursing visits that I ordered for Ronald Wilkes have been denied by Medicare. This letter is to inform you that his care cannot be rendered any less frequently at this time.

I made the home care referral on 7/8/83 because this man had a very large draining abscess on his right buttock. He is unable to care for the ulcer at all due to its location. Initially, the ABC nurses were packing the wound every day. When they had to drop the visit frequency because of Medicare regulations it was found that the packed dressing was inadequate if it couldn't be changed daily.

I then ordered a Hydroactive dressing, since this remains intact longer than others. Since that time Mr. Wilkes' healing has progressed. His ulcer has gone from 9-10 cm. in width and 3 cm. in depth tc 2 cm. by 1 cm.

He still requires application of the Hydroactive dressing and will until it heals. The abscess is located in the right gluteal fold. Because he is incontinent of bowel, it will become severely contaminated without proper care. The proper care is for the nurses to continue at a frequency of 3 x a week. We haven't been able to reduce this yet because the nurses always have found the dressing not to be intact - either because of profuse drainage or because Mr. Wilkes has loosened it inadvertantly while trying to clean feces off the area.

We have made alot of progress with this wound and stopping or decreasing his care would be most detrimental and a setback for the patient. I understand that Medicare is supposed to pay for this type of skilled nursing care when it has been ordered by a physician.

Sincerely,

Russell A. Acree, M.D., P.C.

LAWRENCE J. LYNCH, JR., M.D., F.A.C.S.
JAMES W. MORGAN, JR. M.D.
DIPLOMATES AMERICAN BOARD OF SURGERY
GENERAL AND PERIPHERAL VASCULAR SURGERY

5400 Sutlive Street
Suite 2
68th and Sutlive
Savannah, Georgia 31405

Telephone 355-0433
Hours by Appointment

June 5th, 1984

To whom it may concern

Re: Arthur Jones
Medicare # A704233

The above named patient has been under my care since 1-22-84 suffering with Peripheral Vascular Disease and questionable gangrene of the left foot. He was originally in the hospital from 1-22-84 thru 2-11-84 and was discharged home with daily visiting nurses. This patient is 83 years old, barely ambulatory and completely unable to redress his foot. Besides his visiting nurses aid to cleaning and dressing his wound these visits definately prevented him from being an in-hospital patient. Without the care administered by them he would have been admitted to the hospital. Any and every visit made by the ABC Home Health agency nurses was necessary to his well being and comfort. We feel that the extended care of this agency prevented the patient from definate below the knee amputation of his left leg.

Should you need further information, please contact my office.

Lawrence J. Lynch, J .M.D.

Savannah Plastic Surgery Associates

515 E. 63rd Street — Suite 4
Savannah, Georgia 31405
Telephone (912) 354-3083

E.D. DeLoach, M.D., P.C.
Diplomate, American Board of
Plastic & Reconstructive Surgery

Lawrence E. Ruf, M.D., P.C.
Diplomate, American Board of
Plastic & Reconstructive Surgery

June 18, 1984

Sally D'Arcy, RN
ABC Home Health Services, Inc.
6555 Abercorn Street Suite 222
Savannah, GA 31405

TO WHOM IT MAY CONCERN:

This is to verify that in my medical opinion, Mr. James Bell required twice daily visits from the period during March 1984. Mr. Bell is a senile gentlemen who is unable to care for himself and lives with an aged wife. The wounds which were present on his feet required twice daily nursing visits until family members could be collected and instructed on wound care.

I respectively request that you review the visits of Mr. Bell which were denied in view of these new findings and hope that you will find a favorable ruling for the Home Health Service. If not for the capacity of having such home health services facilities available, Mr. Bell would have required hospitalization for approximately an extra week.

If I can provide further information for you, please do not hesitate to call.

Sincerely,

E.D. Deloach MD

E.D. Deloach, M.D.

EDD:js

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
429 N Street S.W. ● Suite S-605 ● Washington, D.C. 20024 ● (202) 554-0526

STATEMENT
OF THE
AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

ON
INTERMITTENT CARE

BEFORE THE
SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

JUNE 22, 1984

PRESENTED BY
MARGIE MILLS
EXECUTIVE ADMINISTRATOR AND
DIRECTOR OF MEDICAL SERVICES
ABC HOME HEALTH SERVICES
BRUNSWICK, GEORGIA

37-568 O—84——4

SUMMARY

Many disabled and elderly Americans have been denied Medicare coverage of home health services by fiscal intermediaries in a number of states. While Congress works to cut the spiral of Medicare costs through measures such as prospective reimbursement for hospitals, the Health Care Financing Administration and its intermediaries are pursuing short-sighted policies which restrict cost-effective home health services and encourage higher cost institutionalization. Home health providers simply cannot meet the needs of sicker patients entering their care if intermediaries are restricting the services they can provide. One way the home health benefit is being cut is through a restrictive definition of what constitutes intermittent care.

HCFA's own stated policy permits daily skilled nursing visits for two-three weeks and beyond that in unusual circumstances with proper medical documentation. Yet reviewing the cases of denials that have been brought to our attention, it is clear that policy is being disregarded by many fiscal intermediaries. Whether a patient receives the home health care prescribed by his or her physician depends to a great extent on where the beneficiary lives. A beneficiary in one state could receive all the medically-necessary home health services needed, while a beneficiary with the same diagnosis and circumstances in a neighboring state might be denied all home health visits. Meanwhile, HCFA tries to give the illusion of action on this critical problem, but it appears more likely that officials are stonewalling in the hope that Congress will lose interest.

We urge Congress to adopt legislation which would permit 45 days of daily skilled nursing and home health aide visits with appropriate medical documentation (as specified in the Heinz amendment to the Senate Deficit Reduction Act), and to include a clear statement that visits will be permitted beyond the number selected as a guidepost, with physician certification of need. We believe that a prior hospitalization requirement should not be included. Such a provision would preclude many seriously ill beneficiaries from receiving the care they require and would encourage unnecessary hospitalization in order to qualify for the extended number of visits that Congress stipulates.

My name is Margie Mills. I am the executive administrator and director of medical services of ABC Home Health Services in Brunswick, Georgia. We have eight home health agencies in the southern and central Georgia area. I am also a member of the Board of Directors of the American Federation of Home Health Agencies, a trade association representing several hundred home health agencies around the country. Mr. Chairman, I am very pleased to have this opportunity to present testimony to the Health Subcommittee of the Senate Finance Committee on behalf of the American Federation of Home Health Agencies. There are presently many issues troubling the home health industry, but I will focus my remarks today on intermittent care--an issue of critical concern and one you have indicated is the prime topic of this hearing.

The health policies developed by the Federal government are at war with each other. On the one hand, Congress acts to cut the spiral of Medicare costs by implementing a prospective reimbursement system for hospitals, encouraging savings through earlier patient discharge. On the other hand, the Health Care Financing Administration and its fiscal intermediaries, which reimburse providers for services to Medicare beneficiaries, have attempted to restrict the availability of the lower cost Medicare home health benefit at a time when sicker patients are being discharged from hospitals. This action promotes reinstitutionalization, working at cross purposes with the DRG system. Such policy conflict makes no sense, especially at a time when the Medicare trust fund is heading rapidly into the red.

In order to realize short-sighted savings, HCFA and its fiscal intermediaries have attempted to nickel and dime the home health benefit in a variety of ways,

particularly through stricter interpretation of the definition of intermittent care. HCFA's arbitrary restriction of home health services is wasting the hard-earned dollars of the American taxpayers. Saving a dime in home health expenditures often means sticking Medicare with a much larger bill for hospital or skilled nursing home care. Fiscal intermediaries are issuing denials for medically-necessary daily skilled nursing visits beyond a two-three week period, regardless of the fact that a physician has determined that a patient can be cared for adequately at home, does not need to be hospitalized, and no skilled nursing beds are available. Home Health agencies in many states are being prevented from providing cost-effective health care to the Medicare patients most in need of services--the more complex cases being discharged from hospitals under DRGs. As a result, many disabled and older Americans are being denied their right to the home health services that their physicians have ordered and they desperately need.

I believe that it would be instructive here to place this problem within an historical context. Patients are eligible for home health care under Medicare if they are homebound, in need of skilled nursing care, physical therapy, or speech therapy, and a physician establishes and periodically reviews a plan of treatment for them. The Medicare Act, at Section 1814(a)(2)(D), stipulates that home health services are to be furnished to a patient who"...needs or needed skilled nursing care on an intermittent basis or physical or speech therapy..." The Committee Report (89th Congress, House Report No.213) accompanying the Act merely states that the home health benefit covers "part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services...More or less full-time nursing care would not be paid for..."

Congress left it to the agency administering Medicare to develop a definition of intermittent, and over the years, there have been varying interpretations. In the early years, although patients could be seen two or three times a week, visits on a daily basis for any length of time were not considered intermittent care and were therefore not permitted. However, with the diminution of the Medicare SNF benefit, home health agencies began to treat sicker patients. At the same time, the ability to care for more complex cases in the home setting improved dramatically. In an attempt to deal with these changing circumstances, HCFA issued a policy change in 1981, to allow patients to be seen on a daily basis for a period of time.

To enable providers and intermediaries to administer the Medicare program, HCFA has issued a series of Health Insurance Manuals (HIMs). Home health care regulations and policies are contained in HIM-11. The policy change of 1981 as stated in Section 204.1 of HIM-11 permits daily skilled nursing or home health aide visits for up to two-three weeks, and daily visits beyond that provided there is appropriate medical documentation justifying continuation. Sec.204.1 states:

> Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in Section 206.6) medically reasonable and necessary skilled nursing care care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3 week period, the home health agency must forward medical

documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

(Section 206.6, referred to above, sets guidelines for length and frequency of different types of visits.)

As to Congressional intent on intermittent care, the Omnibus Reconciliation Act of 1980 is instructive. In that legislation Congress recognized the changing nature of home health services by eliminating the three day prior hospitalization requirement and the limitation of 100 home health visits per beneficiary period that were part of the original law. With this liberalization, we believe Congress intended home care to be an alternative to inpatient care, providing a patient with whatever number of visits are medically necessary. Congress could have established a maximum number of visits in a specific period or a limit on the frequency of visits, but did not. We believe that the 1980 changes indicate that Congress does not consider daily visits beyond three weeks full-time care that would violate the intermittent requirement.

Circumstances have changed again with prospective reimbursement and the entry of even sicker patients into the home health care system. Despite Congressional intent to expand home care as an alternative to institutional care, as evidenced by the 1980 Reconciliation Act, fiscal intermediaries have in recent months issued interpretations of intermittent care which vary widely from state to state and have the effect of depriving Medicare beneficiaries in many states of needed medical services. Intermediaries in some states allow daily skilled nursing visits beyond three weeks, with physician certification. In other states the outer limit is set at three weeks with no daily visits beyond that point. There are cases of intermediaries setting a two week limit, with only extremely rare extensions beyond that. In several states intermediaries have made retroactive denials of all visits from day one if at the end of a three week period a physician determines that a patient needs further daily skilled nursing visits. These intermediaries claim that patients are not eligible for the home health benefit to begin with if they need more daily visits than fit the intermediary's definition of what constitutes intermittent care.

The result of this policy confusion is that Medicare beneficiaries in one state may be able to receive all the daily visits needed to nurse them back to health, but if they live across the border in a neighboring state and need more than three weeks of daily skilled visits, they could be denied any home health services at all. Some fiscal intermediaries have told home health

administrators that patients whose needs exceed the intermediary's arbitrary definition of intermittent should be institutionalized, even though the home health agencies can successfully and cost effectively treat these patients at home. We are also concerned about an additional source of confusion. During the period daily visits are allowed, some intermediaries permit only one skilled nursing visit per day, while others will allow two or even three.

Many patients are being placed in an untenable position, with no viable options. Very few home health agencies can absorb the financial loss of a large number of denials stemming from an adverse interpretation of intermittent, and even fewer disabled or elderly Medicare patients can pick up the tab for the daily visits they need but that the intermediary refuses to reimburse. Few nursing homes will accept Medicare patients. A beneficiary can seek readmission to the hospital through his or her physician but this defeats the purpose of the DRG system.

Last year, in an attempt to achieve consistency among its intermediaries, HCFA prepared and cleared for issuance a HIM-11 revision that would construe the definition of intermittent along the lines of the strictest fiscal intermediary interpretation, further restricting the already limited circumstances under which patients may receive daily skilled nursing or home health aide visits. Under a storm of protest from Congressional offices and home health providers and associations, HCFA backed off on the manual revision, but the patchwork interpretation of intermittent by the fiscal intermediaries continues.

Congress has stepped in to remedy the intermittent problem. As you are aware, legislation has been introduced in both the House and Senate. The Waxman bill, H.R.3616, would provide Medicare coverage for daily nursing and home health aide visits for up to 90 days, with monthly certification by a physician, and after

that with certification of exceptional circumstances. It also would allow up to 20 aide visits after skilled nursing is no longer required. The Heinz bill, S.2338, would provide coverage for daily nursing and aide visits for up to 60 days with physician certification and beyond that with certification of exceptional circumstances. The Heinz amendment to the Senate Deficit Reduction Act would allow daily nursing and aide visits for up to 45 days following discharge from a hospital and after 45 days with physician certification of exceptional circumstances.

In apparent response to Congressional action, HCFA recently made a weak attempt to introduce consistency by sending a question and answer clarification to its regional offices for transmittal to intermediaries. It is worth noting that the information was not sent directly to the intermediaries as a manual statement where it may have done the most good. The clarification is an improvement on the manual change that HCFA had hoped to issue, but this clarification does nothing more than restate the current policy as set forth in Sec.204.1 of HIM-11 (see above). This is the same policy that HCFA has allowed its intermediaries to interpret in an arbitrary and capricious fashion for so long. And to this day, some intermediaries continue to enforce an absolute three week cut off point on daily skilled visits.

In a May 17 letter to Sen. Warner who inquired on behalf of an AFHHA member in Virginia, HCFA officials indicate that they met with representatives of provider

organizations, and that they are reviewing the definition of intermittent, seeking a legal opinion on daily care beyond a three week period, and considering comments that they have received. We believe HCFA is stonewalling and trying to create an illusion of activity on this problem so that Congress will be neutralized and lose interest. Let me note that the meeting referred to occured last September 15, 1983, and following that meeting, AFHHA submitted comments to HCFA on October 13. Does it really take eight months to review a seven page position paper? We believe HCFA and its intermediaries will simply allow the current confusion to continue if Congress does not act legislatively.

Congressional initiatives are a step in the right direction, but we believe that HCFA and its fiscal intermediaries need instruction beyond the language of the current bills, namely a clear statement of Congressional intent that notwithstanding the number of days Congress specifies for daily visits, Medicare will reimburse for physician-ordered medically-necessary daily visits beyond that arbitrary number. Writing into law a specific number of days will serve as a guidepost for intermediaries and help to alleviate the current confusion. However, we do not believe that a post-hospital requirement should be included in the legislation Congress adopts. Many Medicare beneficiaries who have not been hospitalized have episodes that require daily care over an extended period.

Without daily home health services, some of these patients would have to be institutionalized or else would have to go without crucial care. In some cases physicians would go through the motion of placing patients in the hospital to entitle them to the post-hospital extended number of visits--with Medicare picking up the tab. We also urge Congress to clear up the confusion regarding the number of daily skilled nursing visits permitted, by specifying that two or three visits a day will be reimbursed under exceptional circumstances as certified by the patient's physician.

Mr. Chairman, let me give you just a few examples of patients who conditions warranted daily skilled nursing visits beyond three weeks. In each of these cases the fiscal intermediary issued denials of some or all of the daily visits. As you will note, some of these cases involve patients recently discharged from the hospital; others are representative of patients who suffer from chronic conditions or who are experiencing an episode of illness. The latter do not need to be institutionalized but they often require an extended number of daily visits.

As an example of a patient who is not a post-hospital case, our agency is treating a young man on Medicare disability, a spina bifida patient with a draining abcess in the buttocks area. His wound requires daily packing and dressing, but we were forced to reduce our skilled nursing visits to three times per week after receiving denials from our fiscal intermediary. With aggressive daily packing of his wounds, we believe that his abcess could have been healed in approximately two months. Instead, we are still seeing him a year later. His treatment has now cost much more than it would have if we had been able to continue sterile packing and dressing on a daily basis. In addition, the health and comfort of the patient have been compromised.

Next, let me give you an example of the type of seriously ill patient home health agencies around the country are seeing in increasing numbers, with earlier hospital discharges under DRGs. We treated a 67 year old woman with one rectal and four abdominal abcesses, a draining seven inch abdominal incision, a temporary ostomy, nausea and vomiting, swelling of the arms and legs, and crippling arthritis. Her surgeon ordered daily skilled nursing visits to perform ostomy irrigation and sterile dressing changes. Our intermediary questions whether daily visits to this very sick patient are necessary and has referred the entire case to the Regional Office for a decision on coverage.

We can sucessfully treat this woman for approximately $1200 per month. A bed alone in a nearby hospital would cost Medicare $4500 monthly. And there is not a single nursing facility in our region that will accept this woman as a Medicare patient.

As an example of inexplicable denials on the basis of intermittent, a home health agency in the Midwest treated a patient suffering from a serious wound infection of the right hip following hip surgery. Neither the patient nor his wife is capable of treating the infected wound. The agency provided skilled nursing visits to the gentleman starting approximately a year ago. During some months, the patient's condition necessitated daily visits. The intermediary arbitrarily picked out a three month period and denied all visits as not within the definition of intermittent. Obviously the fiscal intermediary recognized the unusual circumstances of the case and the need for daily visits beyond three weeks because the provider was reimbursed for daily care in the months preceeding and following the denied visits.

To illustrate further the confusion in policy, I cite a case involving arbitrary retroactive denial of all visits to a seriously ill patient. A Visiting Nurse Association treated an elderly woman for a serious chronic bronchial condition. The patient received skilled nursing services five times per week, with Medicare covering three of the weekly visits and Medicaid the other two. The woman, who lives alone, also suffers from congestive heart failure. Without treatment, her condition would develop into life-threatening pneumonia, necessitating more costly hospitalization. The VNA's fiscal intermediary retroactively denied all visits--back to January--claiming that if the woman's condition warranted daily visits over a period of time, she should be institutionalized, not treated under the home health benefit, even though Medicare was only paying for three weekly nursing visits.

To illustrate further the potential cost to the American taxpayer of denial of home health services, another home health agency in the Midwest treated a young quadraplegic Medicare beneficiary who suffered from a number of very severe skin ulcers. The patient's physician determined that the beneficiary did not need to be institutionalized, and could manage quite well at home as long as he had daily nursing visits for packing, dressing, and monitoring of his wounds. A month of home health care, including daily nursing and aide visits as well as all supplies, came to approximately $2900. A month in a nearby hospital would cost at least $11,000, not counting supplies and medications. A month in a skilled nursing facility, without medicine and supplies, would have run close to $5000. The fiscal intermediary denied all visits beyond the first month, claiming that they did not meet the definition of intermittent care.

Mr. Chairman, we are dealing here not with abstractions but with very sick patients--your constituents. I ask your permission to submit for the record photographs provided by a Visiting Nurse Association in the Southwest to its fiscal intermediary to support daily visits to an 80 year old bedridden incontinent patient, a victim of advanced Alzheimer's Disease. The man was discharged from the hospital in December to the VNA for treatment of severe ulcers on his left and right hips and at the base of his spine, involving muscle, fat, cartilage, and bone. The physician prescribed daily treatment of these open draining wounds. The patient responded to treatment, albeit slowly. In early April, the intermediary asked for photos to document the patient's condition, and responded, upon viewing the pictures,"...we understand now why daily visits are being made." However, the intermediary persisted in denying all daily visits for March and April as constituting more than intermittent care and therefore not reasonable and necessary. These photographs indicate a patient in desperate need of daily care, and one who is "consistently improving" thanks to the "diligent work of the nurses" at the VNA, in the words

of the patient's doctor. But this is a beneficiary denied coverage under Medicare for not falling within one fiscal intermediary's arbitrary definition of intermittent care.

Mr. Chairman, these cases speak for themselves. We urge you to take immediate action to remedy a situation that encourages higher cost institutionalization to be substituted where lower cost home health services are not only adequate, but the preferred method of treatment for beneficiaries who wish to remain, with dignity and independence, in their own homes.

Representatives of AFHHA would be happy to provide further information and assistance to you and committee staff in resolving this critical problem. Thank you for the opportunity to present our testimony here today.

STATEMENT OF SISTER BRIGIDA CASSADY, EXECUTIVE DIRECTOR, HOSPITAL HOME HEALTH SERVICES OF MINNESOTA, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Senator DURENBERGER. Sister Brigida.

Sister BRIGIDA. Mr. Chairman, and members of the subcommittee, I am Sister Brigida Cassady, director of Hospital Home Health Services of Minnesota, a multi-institutional hospital sponsored home health agency in Minneapolis.

I'm speaking on behalf of the American Hospital Association, an organization which represents over 6,300 hospitals and nearly 1,000 hospital based home health programs today.

We welcome this opportunity to present our views on the intermittent care requirement under consideration today, and to offer our perspective on current policies as they affect the patients under our care.

Home care has changed radically since medicare was enacted. Due to the advances in medical technology, aging of the population and declining hospital lengths of stay, it has emerged as a vital component of the health care continuum, providing necessary posthospital followup care in an appropriate and cost effective setting, and keeping numerous elderly patients from being sent to nursing homes unnecessarily.

More and more highly complex procedures can now be performed safely at home. Intravenous antibiotic therapy, intravenous chemotherapy, and antra and parentral nutrition are examples.

As a result, home care professionals no longer perform only basic tasks. They administer complex plans of care to interdisciplinary teams. They also serve as educators, leading patients toward independent self-care.

Unfortunately, although Congress in 1980 liberalized the medicare home health benefit, the Health Care Financing Administra-

tion simultaneously initiated a new cost control program that has had the effect of limiting eligibility. Fiscal intermediaries under pressure to meet federally prescribed performance standards have imposed restrictive utilization screens and burdensome documentation requirements.

The intermittent care requirement, in particular, is being interpreted to exclude from coverage those patients who need more than 3 weeks daily nursing care. I can give numerous examples from my experience in Minnesota of patients who are ideal candidates for home care, but who either are being rehospitalized or are forced to break up their homes and enter nursing homes, or who, in the worst cases, are simply being denied care because we cannot predict that their treatment will be completed within 3 weeks.

The provision in the Senate version of H.R. 4170, which would have allowed 45 days of daily home care after hospital discharge, would alleviate this situation. But Congress really should go further and restructure the home care benefits in light of changing trends in health care delivery.

Coverage and payment policies should be revised to encourage providers and beneficiaries to make appropriate use of hospitals, skilled nursing, and home care services. And these revised policies should be published as regulations to ensure consistency and fairness in their implementation.

Since one picture is really worth a thousand words, I would just like to show five slides that will illustrate the dramatic changes in the type of home care that we have previously practiced, probably 5 to 6 years ago, and what has happened with modern technology. I feel that the technology is available for the elderly to be cared for in the home, but reimbursement has to follow that technology in order to care for these patients.

[Showing of slides.]

Sister BRIGIDA. There are only five slides. And this first one, I think, for most people who are not very familiar with home care illustrates what traditional home has been. The bathing of the patient, making the patient comfortable. And while that still is a necessary goal for skilled nursing, it is not the thing that is happening today.

Evaluating medications has always been a skilled nursing procedure and recommending to the patients what type of medication the doctor had ordered. But currently we have a complex type of medication regime for most patients. The elderly patients receive many medications which may have interactions and so sometimes the initiation of a complicated medication regime may require daily visits so that those medications do not have a dangerous effect. Observation of adverse symptoms demands a skilled nursing visit and instruction on methods of administration are necessary.

[Changing of slides.]

Sister BRIGIDA. One of the purposes of the slides is that when we talk about "intermittent" or "hyperalamentation" or a "hickman catheter," they are in the abstract. This is a picture of an actual patient who has a hickman catheter, and is receiving hyperal—who previously most of us would have considered had to be hospitalized for this very precarious type of procedure. Today it is becoming more commonplace because of the technology. There are many new

kinds of IVAC, pumps, IV packs, et cetra, et cetra, that can be used with the hickman catheter. This gentleman's entire gut has been removed and so this is his primary source of nutrition. The wife has to have instructions with this machine and catheter in order for her to carry out this particular procedure. And it takes some time to teach the person to do this daily teaching is necessary until one person is competent.

[Changing of slides.]

Sister BRIGIDA. A wound—someone else has also mentioned this—often requires daily dressings, packing. There are different types of irrigations that are being promulgated now. Particular antibiotic types. Observation and teaching needs to be an ongoing procedure.

[Changing of slides.]

Sister BRIGIDA. This illustrates the IV antibiotic therapy that is initiated. A gentlemen having a very complicated lung infection. The son was willing to take on the instruction, and it was a complicated instruction at that time. This is 1 year ago. And the site where the I.V. is inserted in the arm usually is a common infection site. He learned that treatment so well that we only eventually had to go out once a week and that site remained free of infection. This gentleman was able to remain out of one hospital setting for 9 months.

I wish that this was a colored slide because the elderly gentleman, when we went out to take his picture, had purchased new white suspenders particularly for the occasion. [Laughter.]

[Changing of slides.]

Sister BRIGIDA. This is a patient who has a very rare sclerosing cholangitis disease. She couldn't look at her wound initially. When the preparation was being made for her to home. This catheter is a permanent catheter which provides irrigation to the sclerosing area. Ultimately, after repeated visits, she was capable of taking care of that wound and the catheter and she now walks around and takes care of irrigating that catheter and only needs a visit probably once a month for a new type of irrigation to be initiated or electrolytes to be evaluated.

[Changing of slides.]

Sister BRIGIDA. This pain control is another thing that we are teaching families now, which has come into vogue as patients' medication can be put on an ongoing regime for particularly painful situations. This happens to be a cancer patient and the husband learned to give one morphine for pain control.

[Changing of slides.]

Sister BRIGIDA. The last slide that I am showing is one to demonstrate other skilled nursing needs. This gentleman had a massive lung disease. He wanted to demonstrate to us, when we were showing pictures, that a lot of support had been given to him at home by nursing. He had thought that his wife might get the disease. And we gave a lot of support in telling him that this would not happen. Instruction and professional support gives confidence.

He said that when I showed this picture—and this was quite some time ago—that he wanted people to know that there was life in the old boy yet. [Laughter.]

When I showed this to a group of physicians, they asked if that was the home care nurse. [Laughter.]

One of the physicians replied, no, Medicare does not cover that. [Laughter.]

Senator DURENBERGER. Shame on you, Sister, but that was a good slide.

Sister BRIGADA. I want to thank the committee for the opportunity to appear before you. And I will be happy to answer any of your questions.

Senator DURENBERGER. Thank you very much. That was very helpful.

[The prepared statement of Sister Brigida Cassady follows:]

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STATEMENT OF SISTER BRIGADA CASSADY,
EXECUTIVE DIRECTOR,
HOSPITAL HOME HEALTH SERVICES OF MINNESOTA

on behalf of the

AMERICAN HOSPITAL ASSOCIATION

before the

SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

on

HOME CARE AND THE MEDICARE INTERMITTENT CARE REQUIREMENT

JUNE 22, 1984

SUMMARY

Home care has changed radically since Medicare was enacted, due to advances in medical technology and reductions in hospital lengths of stay. Congress in 1980 liberalized the home care benefit to provide an alternative to institutionalization, but the Health Care Financing Administration concurrently initiated a new cost-control program that in effect limited eligibility. Regional intermediaries, motivated by new fiscal performance standards, have imposed restrictive screens and burdensome documentation requirements.

A strict interpretation of the "intermittent care" requirement prevents home care patients from receiving daily nursing visits beyond 21 days. This has excluded from coverage elderly patients who need daily post-hospital follow-up care for a longer period. Such patients are often institutionalized unnecessarily. To address these problems, the American Hospital Association recommends that:

(1) The provision in the Senate version of H.R.4170 which would allow Medicare beneficiaries up to 45 days of daily home care after hospital discharge is moderate and workable, and should be adopted. However, this expanded benefit must be accompanied by increased funding.

(2) Regulations should be promulgated clarifying basic home care definitions and providing for public comment on eligibility and coverage rules.

(3) Congress should restructure the home care benefit as a key part of the health care continuum, ensuring that coverage and payment policies encourage providers and beneficiaries to make efficient and appropriate use of acute inpatient, skilled nursing, and home care services.

(4) Congress should give attention to the question of whether home care services should be included in the Medicare prospective payment system.

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Sister Brigada Cassady, director of Hospital Home Health Services of Minnesota, a multi-institutional hospital-sponsored home health agency in Minneapolis. I am speaking on behalf of the American Hospital Association (AHA), an organization which represents over 6,300 hospitals and nearly 1,000 hospital-based home health agencies. We welcome this opportunity to present our views on national home care policy in general, and on the Medicare intermittent care requirement under consideration today. We are glad to offer you our perspective on how current policies are affecting the patients under our care.

Most hospitals today participate in home care, if not as direct providers of services, then in affiliation with one or more home health agencies in their communities. According to a recent survey by the Department of Health and Human Services, the great majority of home care patients is referred to that service by hospitals.[1] AHA believes home care is a potentially vital component of our health care system, that can ensure continuity of care between inpatient and outpatient settings, and thereby make possible more efficient use of acute inpatient resources. Home care can also provide a less costly alternative to nursing home care when Medicare beneficiaries do not require continous supervision.

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[1] "Changing Patterns of Entry to Home Health Services," U.S. Department of Health and Human Services, Office of the Inspector General, November 1981.

A well designed home-care benefit can increase the satisfaction of Medicare beneficiaries by providing services in their homes, while at the same time reducing the total cost of the program by preventing unnecessary institutionalization. Whether these goals will be achieved depends on the structure of consumer and provider incentives created by Medicare payment and benefit policies, and on the ability of the program to ensure the consistent and equitable application of these policies. Incentives should encourage the efficient production and use of home health services, while enabling Medicare beneficiaries to obtain services in the setting they prefer.

Historically, the policies of the Department of Health and Human Services have focused on encouraging appropriate use of home health services. These policies have reflected assumptions appropriate to a system of retrospective cost-based payment for both home health and acute inpatient services. Recent changes in Medicare reimbursement policies necessitate a re-evaluation of the appropriate role of home care in meeting the needs of the Medicare population. We commend the Subcommittee for undertaking this much-needed policy review, and urge you to approach this task from a broad perspective, recognizing that the problems of home care can only be solved in the broader context of the full range of services covered by Medicare.

CHANGES IN HOME CARE AND IN MEDICARE COVERAGE

When Medicare was first enacted, Congress appended a limited home care benefit to the basic hospital coverage: after hospital discharge a beneficiary was allowed up to 100 home health visits a year under Part A; another 100 visits

were available under Part B with no requirement of prior hospitalization. At that time Congress envisioned a straightforward home nursing service for convalescing patients.

As the Medicare population's need for long term care increased, home care was identified as an alternative to placement in a Skilled Nursing Facility or Intermediate Care Facility. Congress, in the 1980 Omnibus Reconciliation Act (P.L.96-499), expanded the home care benefit by eliminating the Part A prior hospitalization requirement and the 100-visit limitation under both parts. Home care was at that point perceived not as a minor adjunct to hospital care, but as an integral part of the health care continuum and cost-effective substitute for institutional care.

Meanwhile, fundamental changes were taking place in the nature of home care services and in the kinds of patients served. Advances in medical technology were making it feasible to perform complex, technologically sophisticated procedures at home: for example, intravenous chemotherapy, antibiotic therapy, and enteral and parenteral nutrition. Many of these procedures did not even exist when the home care benefit was first established. As these developments were occurring, Medicare medical review policies, which emphasized reducing hospital lengths of stay, were causing patients to be discharged at an earlier stage of recovery.

The net result of these two trends is that home care professionals no longer perform only basic nursing tasks. They administer complex plans of care

through interdisciplinary teams. And, more than ever, they serve as educators, leading patients toward independent self- care and encouraging family members to act as care-givers.

FISCAL PRESSURES AND PAYMENT POLICIES

In the 1980s home care's emergence as a fully developed mode of health care delivery collided head-on with the fiscal pressures generated by rising Medicare outlays. While Congress liberalized the home care benefit, it did not also provide necessary additional funding. Accordingly, in 1980 the Health Care Financing Administration (HCFA) launched a major effort to hold the costs of the program within the limits of available funds. Unfortunately, the agency has attempted to accomplish its goals by means of instructions to fiscal intermediaries, rather than by formal promulgation of regulations, which would have provided an opportunity for public comment. Despite these efforts to control costs, home health care is today the most rapidly growing component of the Medicare program.

HCFA created a new system of regional intermediaries to process the claims of freestanding agencies; these new entities were expected to apply uniform utilization and coverage screens. Hospital-based agencies were allowed to continue dealing with the hospital's intermediary, but they were subject to the same screens as the freestanding agencies. Audits were conducted of the intermediaries' performance.

Many fiscal intermediaries have interpreted HCFA guidelines as requiring tighter limitations than the agency intended. A more serious problem has been their increased emphasis given to financial rather than medical factors in determining when the services provided to a patient would be paid. A pattern has emerged of excessively strict interpretations of eligibility and coverage guidelines, inconsistent interpretations by different intermediaries, increasing numbers of claims denied, and withholding of payment from providers while claims are being reviewed.

INTERMITTENT CARE

The Medicare statute requires that home care patients be in need of skilled nursing and home health aide services on a part-time or "intermittent" rather than a continuous basis [Social Security Act, secs. 1814(a)(2)(D), 1835(a)(2)(A), and 1861(m)]. Fulfillment of the intermittent care requirement is therefore a key to eligibility for all home care services; unfortunately, there exists no formal regulatory definition of the term.

Over the years HCFA, in its instructions to intermediaries, has been groping for a satisfactory definition; to the agency's credit, it has recognized the need for flexibility and the importance of tying the requirement to the medical needs of the individual patient. Nevertheless, HCFA's interpretations have become progressively more stringent.

In 1975 the Department defined "intermittent" as "service for a few hours a day several times a week," and suggested 100 hours a month as a norm for home

health aide service. The norm soon became a cap, and the principle was established that "intermittent care" could not be provided seven days a week except in unusual circumstances. In 1981 and 1982 HCFA drastically reduced the guidelines for numbers of hours and visits, but allowed for circumstances in which longer and more frequent service might be needed. If adequately justified, home health aide service could be provided seven days a week for a two-to-three-week period (Home Health Agency Manual Transmittal 127 and 137). This guideline also became a limit, and is currently being enforced as such. However, last April HCFA, reacting to numerous complaints, advised its Regional Offices that daily care might be allowed for more than three weeks under unusual circumstances, but that any extension should be strictly limited and carefully reviewed. Nevertheless, the agency wisely refrained from setting a fixed limit on the amount of daily care to be covered, and emphasized that the medical necessity and appropriateness of the service should be the paramount consideration.

HCFA's current guidelines are too restrictive; however, the real problem is not the guidelines, but their erratic and excessively stringent application by intermediaries who must give primary emphasis to financial performance standards in making coverage determinations. Targets unrelated to patients' needs inevitably produce unfair decisions. A secondary problem is that instructions to intermediaries are not subject to formal public notice and comment procedures. Consequently, coverage determinations are often based on standards of which providers are unaware. Regulations are sorely needed to achieve consistency and fairness in implementation and to provide an opportunity for public comment.

THE IMPACT ON PATIENTS OF THE INTERMITTENT CARE REQUIREMENT

The intermittent care guidelines as actually interpreted are having a disastrous effect on beneficiaries. Elderly patients who need daily post-hospital follow-up care for longer than three weeks, and who may not have a family member available or able to carry out complex procedures, are particularly at risk. A few examples can be drawn from my own experience in Minnesota:

- A 75-year-old woman with cancer of the breast has a deeply infected wound near the brachial artery as a result of radiation treatment. The wound needs daily irrigation and debridement because of its location near vital areas. The patient cannot perform the procedure herself. Though the wound had not healed, the intermediary denied visits beyond 21 days in accordance with the new interpretation of intermittent care, and advised that the patient should be in a nursing home.

- An alert, independent 70-year-old woman with endocarditis needs daily antibiotic therapy with a Hickman catheter for two months. She is capable of learning all the procedures necessary to administer the therapy, but will need daily visits until she learns how to do so; after that she will need periodic nursing visits to prevent complications. Though she is an ideal candidate for home care, the intermediary will not allow the agency to accept her because daily therapy may extend beyond 21 days.

- o A 58-year-old disabled Medicare patient has had gastric by-pass surgery and has developed postoperative complications, including an infected sinus tract. Daily irrigation is necessary, and the patient cannot perform the procedure and has no family member or friend available to help. Again, the intermediary will not allow payment.

These patients are not in need of acute care. To keep them in a hospital for weeks or even months would be a wasteful use of Medicare's resources. They do not belong in nursing homes, as they do not require constant supervision. Even when a nursing home might be a suitable alternative, they would not necessarily require "skilled nursing" care, and Medicare does not cover intermediate care. Unless these patients are able to pay for nursing home care, home care is the only alternative. Even if Medicare were to cover nursing home care, and a nursing home bed was available, home care may well be less costly than institutional care. Under current Departmental policies, however, these patients will often not qualify for coverage of home health services because their care exceeds that permitted under the intermittent care requirement. They often have nowhere to turn.

RECOMMENDATIONS

The legislation before this Subcommittee would address the needs of these patients by allowing up to 45 days of daily care following a hospital discharge, and a possible extension beyond that time in exceptional

circumstances. It is a moderate and workable proposal, and recognizes the care must be coordinated across the acute inpatient and outpatient settings in order that incentives created by the Medicare prospective pricing system may result in the most efficient use of the program's resources. However, it is likely that his legislation will lead to increased use of home health services and increased program expenditures. Because the unmet need for home health care is so large, as has been shown by General Accounting Office studies, lower costs resulting from substitution of home care for other services could well be counteracted by the expanded volume of services by new home health patients. Consequently, any expansion of the home health benefit must be accompanied by increased funding. If it is not, HCFA as in the past, will probably be forced to limit availability of services using financial rather than medical criteria.

Earlier this week the AHA presented testimony before the Senate Committee on Labor and Human Resources describing the dramatic reduction in the rate of increase in hospital costs that has resulted as hospitals respond to the new incentives created by prospective pricing. In a press release issued earlier this week, Secretary Heckler also indicated that the increase in total Medicare outlays has been held to the lowest level since the creation of the program. Home health care can play a vital role in ensuring the continuation of these trends. It can do so, however, only if coverage and payment policies encourage and enable providers and beneficiaries to make efficient and appropriate use of acute inpatient, skilled nursing and home care services.

The proposed legislation deals with one limited aspect of the home care problem. It is important to consider this proposal in the light of the larger question of whether home health services should be included in the Medicare prospective payment system. These issues can be resolved only within the broader context that considers both beneficiary needs and the role of home health services in meeting those needs. The AHA has been a proponent of approaches relying on incentives, and believes this approach is as applicable in the area of home health care as in the area of acute inpatient care. We will be happy to continue working with you in this endeavor.

STATEMENT OF ROSEMARY A. BOWMAN, PRESIDENT, HEALTH CARE PARTNERS, INC., NASHVILLE, TN

Senator DURENBERGER. Ms. Bowman.

Ms. BOWMAN. Senator Durenberger, it's a pleasure to have the opportunity to speak to you this afternoon. I am Rosemary Bowman, president of Health Care Partners of Nashville, TN.

And with me, behind me, is Fran Adkins, who is chairman of Health Care Partners.

Our organization owns and manages five medicare certified home health agencies in three States. We have many years of experience within the home care field. At the time of the onset of this issue—I want to go back a bit—in 1982, our organization had agencies only in Colorado and Tennessee. Our fiscal intermediaries were Blue Cross of Colorado and Blue Cross of Tennessee. Our first indication of a change of policy relative to daily visits was a bulletin from Blue Cross of Tennessee dated August 1982.

From September to December 1982, the Colorado fiscal intermediary made no notification of the changes in the intermittent rules. They did, however, begin denying daily visit cases without notification of the reason. Their multiple denials during this period resulted in over one-half of the home health agencies in Colorado losing their waiver of liability. The formal notification to Colorado agencies regarding the changes in the intermittent rule was not distributed until February 1983. There is an issue of application of guidelines and flexibility by the intermediaries. The intermediaries, in our experience, are using the 2- to 3-week limit as an absolute. They are not using judgment relative to the submission of additional information to them.

The Tennessee intermediary gave lipservice to consideration of extension of daily visits, but never granted any extensions when they were requested. In one Nashville case involving a brittle diabetic with a new stroke, even though the professional staff of the agency, the physician, the patient and the family believed that the

required daily care was best provided in the home, the fiscal intermediary encouraged hospitalization.

The dilemma of home health agencies in this issue is that HCFA and the intermediaries are discouraging noninstitutional care in an environment that is otherwise encouraging noninstitutional care. If a patient meets the requirements of being homebound, the care is reasonable and necessary, and the patient is unstable but improving, it makes little sense to require hospitalization, in. particular institutionalization of any type because the care has reached some arbitrary time limit.

The ultimate effect of the daily visit limitations will hurt patients; not save big dollars for HCFA.

We have reviewed the cases that have required daily visits by our agency since August 1982. At no time have we have had more than 2 percent of our medicare patients on daily visits. Since the change went into effect, we have had only five daily cases go over 3 weeks in duration. Most daily cases have lasted about 1½ weeks. At the present time, we have no daily medicare cases out of a total case load of roughly 250 patients.

Our review and that of other organizations suggest to us that the need for daily visits is minimal, but for those individuals that need that care, it is great. The most frequent demand for daily visits is for patients needing wound care. That has already been discussed substantially.

Three weeks of daily visits is sometimes not sufficient to achieve healing or to complete the patient and family teaching that is required for wound care. The most frequent needs for daily visits, additional needs, are terminal care, complex diabetics and complex hospital discharge.

Approximately two-thirds of our patients requiring daily visits are discharged from the hospital to home. The remaining one-third are not hospitalized. Given the concern for cost reduction and the trend toward noninstitutional care, it makes little sense to force them into a hospital or skilled care facility. Home care is being provided in lieu of hospitalization.

It is our experience that the types of patients who need daily visits are quantifiable and can be classified by systematic description. It is our recommendation that you adopt an outside limit of 45 days of daily care. In addition, guidelines for daily visit needs for specified diagnoses within that 45 daily visit limit should be established.

For example, using a 45-day limit visit, the range of visit guidelines set for stabilizing a complex hospital discharge could be 5 to 7 days. It is further our recommendation that such guidelines provide for an individual review of need to go beyond that 45-day limit, given unusual circumstances. It is our experience that the need for daily visits is an exception to the norm. In order to monitor the appropriateness of daily visits, we recommend that daily visit charting be sent to the fiscal intermediary with all daily visit billing. Blue Cross of Tennessee already requires this practice. One of the concerns by HCFA is that we be able to justify and that we be able to validate the need for this service. We are willing to submit the documentation to do that.

We further recommend that Congress recognize that daily home visits are a viable option to more expensive hospitalization. The 45 day daily visit provision should be allowed in lieu of hospitalization as well as posthospitalization.

We thank you for the opportunity to make this presentation to you. And look forward to the improvement of this issue.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Bowman follows:]

Senate Finance Committee Subcommittee on Health

Senator Dave Durenberger, Chairman

Intermittent Care

June 22, 1984

by

Rosemary A. Bowman

Summary

We have reviewed the cases that have required daily visits by our agencies since August 2, 1982. At no time have we had more than 2% of our Medicare patients on daily visits. Since the change went into effect, we have had only two daily cases in Nashville to go over three weeks in duration. Only three daily cases in Denver have gone over three weeks. Most daily cases have lasted about one and one-half weeks. At the present time, we have no daily Medicare cases out of a total case load in excess of 250 patients.

Approximately two-thirds of our patients requiring daily visits are discharged from the hospital to home care. The remaining one-third are not hospitalized, and based on professional judgment, their treatment site of choice is their home. Furthermore, given the concern for cost-reduction and the trend toward non-institutional care, it makes little sense to force them into a hospital or skilled care facility. Such daily home care is being provided in lieu of hospitalization.

Recommendations

1. Since the debate regarding intermittent care questions Congressional intent, we believe that it is appropriate for the Congress to state its intent by amending the statute.

2. It is our recommendation that you adopt an outside limit of 45 days of daily care. In addition, guidelines for daily visit needs for specified diagnoses within that 45 day limit should be established.

3. In order to monitor the appropriateness of daily visits, we recommend that the daily visit notes be sent to the fiscal intermediary with all daily visit billing.

4. We further recommend that the Congress recognize that daily home visits are a viable option to more expensive hospitalization. The 45 daily visit provision should be allowed in lieu of hospitalization as well as post-hospitalization.

Testimony

Senate Finance Committee Subcommittee on Health

Senator Dave Durenberger, Chairman

Intermittent Care

June 22, 1984

by

Rosemary A. Bowman

President

Health Care Partners

and

Fran Adkins

Chairman

Health Care Partners

Senator Durenberger and members of the Senate Finance Committee, we are pleased to have the opportunity to address you today on the subject of intermittent care.

I am Rosemary A. Bowman, President of Health Care Partners of Nashville, Tennessee. With me is Fran Adkins, Chairman of Health Care Partners and Chief Operating officer for our home health division.

Health Care Partners owns and manages five Medicare certified home health agencies in three states. The leaders of our organization have many years of experience within the home health field. We have experienced many transitions in the Medicare home care program.

Daily Visit Problem

In the summer of 1982, the Health Care Financing Administration (HCFA) announced a change in the meaning of intermittent care. By that action, HCFA effectively reduced the Medicare home health benefit without providing an opportunity for public comment. The number of Medicare recipients who are affected by this change is relatively small. The real impact on that small number of older people is, however, quite significant.

We want to share with you the impact of that change, both on Medicare beneficiaries and the home health providers. We will reference the issue as daily visits.

At the time of the onset of this issue, last year, our organization had agencies only in Colorado and Tennessee. Our fiscal intermediaries are Blue Cross/Blue Shield of Colorado and Blue Cross/Blue Shield of Tennessee. Our first indication of a change of policy relative to daily visits was a bulletin from Blue Cross/Blue Shield of Tennessee dated August, 1982 and received in September, 1982 (Appendix A). Our Nashville agency had one daily case at that time, and a concerted effort was made to meet the documentation requirements

for this daily case. In late December, 1982, we received notification that the patient's daily visits were to be denied.

A Case History

The following account is a letter of rebuttal regarding the denial of this patient's care sent to Blue Cross/Blue Shield of Tennessee. We include it to illustrate the nature of his care and our understanding of the documentation required to justify daily home health visits.

> We received a denial on Mr. H. for dates of service 8/1/82 through 8/31/82. I believe his skilled nursing care was intermittent and request a reconsideration.
>
> Mr. H's diagnoses are as follows:
>
> 1. Cerebralvascular accident 6/82 and 7/10/82
> 2. Congestive heart failure
> 3. Wounds secondary to fragile skin/skin breakdown
> 4. Chronic bronchitis
> 5. Peripheral vascular disease
> 6. Cerebrovascular disease
> 7. Rash
> 8. Easy bruisability
> 9. Hypertensive artery disease
> 10. Psoriasis
> 11. Chronic renal failure
> 12. Aortic aneurysm
> 13. Incontinence
> 14. Gangrenous left great toe 8/27/82
>
> Mr. H had his second stroke 7/10/82 at home after having been in the hospital with the first one in June. The second stroke left his left hand and arm partially paralyzed and his mental capabilities further damaged. Dr. K determined that hospitalization was not necessary since Health Care at Home was capable of giving good care at home and the family was supportive and willing to have him there. Dr. K felt Mr. H was terminal.
>
> After the new stroke, Mr. H began having severe episodes of skin breakdown on his arms, particularly his newly paralyzed arm. The RN taught the daughter sterile dressing technique and how to apply neosporin ointment. Teaching was expanded in the areas of how to prevent skin damage in the course of caring for Mr. H, turning him, positioning him, pulling him up in bed, putting him on and off the commode, and getting him in and out of bed.

On 7/25/82 Dr. K ordered daily nursing visits to change the dressings on Mr. H's arm because the daughter was unable to use sterile technique due to Mr. H's inability to cooperate. His uncontrollable and spastic movements during the procedure resulted in contamination of the dressings and wounds. The wounds, therefore, became infected.

It was anticipated at this time that the wounds would heal promptly with daily skilled nursing care, that the preventive teaching would be effective, and that there would be no further need for daily visits in 2-3 weeks.

Unfortunately, it was found that just the pressure to hold Mr. H when he would spasm and rear backwards when being moved was enough to cause small hemorrhage areas that would later break down as open wounds. This required a variety of protective measures directed at preventing these wounds. Therefore, more time was needed to achieve Dr. K's goals than was initially anticipated. On 8/13/82, Dr. K ordered daily visits be continued plus new ways developed to protect Mr. H from injury.

Also on 8/13/82, Dr. K ordered daily visits for a new condition. Acute deterioration of circulation in Mr. H's left great toe resulted in the development of eschar that spread down and into the toe. Twice daily dressing changes were ordered as follows:

> 2 x/day Dunborough soaks wet — dry
> covered with dry sterile dressing

The daughter was to be taught to do this 1x/day, and the RN was to do it the other while observing for increasing circulatory problems.

It was anticipated that the daily visits would be needed for only a short period of time, that the eschar would be removed, and the toe would heal.

8/27/82 Mr. H accidentially bumped his toe and it hemorrhagged under the skin. The damaged area was the size of a fifty cent piece. This area became gangrenous almost overnight. It was surrounded by a swollen, errythematous toe, and half of the ball of his foot. This errythematous area lacked blood circulation and was also in danger of becoming gangrenous. There was also danger of infection.

Dr. K determined that hospitalization was not necessary and that daily skilled nursing visits should continue at home. Dr. K changed the orders for the toe 8/27/82 and again on 8/31/82 for this new condition. They became as follows:

1. Dressing change 2x/day - RN doing it 1x/day and also observing for increasing circulatory problems as well as reinforcing measures to promote circulation in that foot and toes

   warm soak 2x/day in epson salts
   cleanse with H_2O_2 1/2 strength
   apply betadine ointment
   saline soak wet — dry 2x/day
   dry sterile dressing

2. Keflex susp. 250 MG/TSP QID x 10 days
3. Mellaril 25-50 MG. HS PRN aggitation

This care plan anticipated reduction of daily visits in three weeks.

On 9/23/82, it was noted that the errythemia in Mr. H's toe was reduced but not absent as had been anticipated. There remained the danger of extension of the gangrene and thus the need for daily skilled nursing observation and continuation of measures to increase circulation to the toe. Dr. K ordered skilled nursing visits to continue daily for another three weeks. The orders were changed as follows to speed up the debriding process:

Change:
warm soak 2x/day in epson salts
cleanse with H_2O_2 1/2 strength
apply betadine ointment
dunboroughs soak wet — dry 2x/day
dry sterile dressing

On 10/15/82, the errythema was gone, and it was determined that skilled nursing visits were no longer needed daily and that 3x/week were sufficient to continue the debriding process, remove the eschar, promote circulation, reinforce teaching, and prevent infection. The gangrenous area has since fallen off and the toe is nearly healed. In the process of the gangrenous area falling off, a small flat, sharp piece of either bone or toe nail material imbedded deep in the toe for many years fell out. This material probably contributed to the hemorrhage and the slow healing process.

In summary, I believe Mr. H's care was intermittent,

1. He did not require institutionalization as determined by the physician.
2. Daily skilled nursing care was anticipated to be of short duration.
3. The short duration anticipated for the skilled nursing care was noted on the care plans after 9/15/82 as required in Home Health Agency Bulletin No. 1 and,

> 4. Daily skilled nursing care as required for different and unanticipated conditions.
>
> If daily skilled nursing care had not been provided by Health Care at Home, Mr. H would have gotten sicker, would have probably lost his toes and maybe his foot, and a long hospitalization would have been required.

Following submission of this letter, no further communication was received by the patient or by us regarding the denial.

During the same period, from September to December, 1982, the Colorado fiscal intermediary made no notification of the changes in the intermittent rules. They did, however, begin denying daily visit cases without notification of the justification. Their multiple denials during this period resulted in over one-half of the home health agencies in Colorado losing their waiver of liability. The formal notification to Colorado agencies regarding the changes in the intermittent visit rule was not distributed until February, 1983 (Appendix B).

The impact of the change on patients and providers has been complex. The initial impact on providers was to create uncertainty regarding the meaning and scope of the change. It was not until the denials came that the gravity of the change became apparent.

Our first step was to seek clarification regarding the scope of service that was allowable and the documentation that would be required to justify the care that was being provided. The notification from the fiscal intermediaries noted that the initial period of two to three weeks of daily visits could be extended in unusual circumstances. Our Denver agency had one case that needed daily visits beyond the three week period. The circumstances were explained to the intermediary and a verbal O.K. was received to continue daily visits. Six more daily visits were made before the frequency could safely be reduced. In spite of the verbal O.K. for continuation, when the billing and documentation were submitted, the six additional visits were denied.

The Tennessee intermediary gave lipservice to consideration of extension of daily visits, but never granted any extensions when they were requested. In one Nashville case, even though the professional staff of the agency, the physician, the patient, and the family believed that the required daily care was best provided in the home, the fiscal intermediary encouraged institutionalization.

The results of multiple denials of daily visits is that agencies excede the 2.5% limit on denials and lose their waiver of liability. Once the waiver is withdrawn, payment will not be made for any denial visits made during the following quarter. As noted above, the change was put into effect in Colorado although agencies were not notified. Denials were received and agencies lost their waiver of liability, even though they did not know the reason. The impact of such action by the intermediary is to make agencies overly cautious about providing any daily care, even though it is fully justified and the patient need is clear. Our organization made the decision, however, that we would not turn away daily visit cases.

The dilemma of home health agencies in this issue is that HCFA is discouraging non-institutional care in an environment that is otherwise encouraging non-institutional care. If a patient meets the requirements of being homebound, the care needed is reasonable and necesary, and the patient is unstable but improving, it makes little sense to require institutionalization because the care has reached an arbitrary time limit. In our experience to date, the time limit is being applied with little or no flexibility.

We have reviewed the cases that have required daily visits by our agencies since August, 1982. At no time have we had more that 2% of our Medicare patients on daily visits. Since the change went into effect, we have

had only two daily cases in Nashville to go over three weeks in duration. Only three daily cases in Denver have gone over three weeks. Most daily cases have lasted about one and one-half weeks. At the present time, we have no daily Medicare cases out of a total case load in excess of 250 patients.

Our review and that of other organizations suggests to us that the need for daily visits is minimal. The most frequent need for daily visits is for patients needing wound irrigations or dressing changes for slow healing wounds or wound infections. In most of these cases, three weeks of daily visits is not sufficient to achieve healing or complete the patient or family teaching that is required for wound care. The next most frequent needs for daily visits, in order of frequency, are terminal care, giving or teaching administration of insulin, and transitioning a complex hospital discharge.

Approximately two-thirds of our patients requiring daily visits are discharged from the hospital to home care. The remaining one-third are not hospitalized, and based on professional judgment, their treatment site of choice is their home. Furthermore, given the concern for cost-reduction and the trend toward non-institutional care, its makes little sense to force them into a hospital or skilled care facility. Such daily home care is being provided in lieu of hospitalization.

Recommendations

Since the debate regarding intermittent care questions Congressional intent, we believe that it is appropriate for the Congress to state its intent by amending the statute.

The daily visit issue originated from the redefinition of the term "intermittent." Intermittent has now been changed from a limited length of time in a day to a limited length of time over a period of days. The Medicare home care benefit never intended full-time care. It is not our expectation

that Medicare should pay for extended hours of care. It is our expectation that the Medicare home care benefit intended to cover visits of a short duration to be made at a frequency justified by patient care need.

It is our experience that the types of patients who need daily visits can be classified by systematic description. The number of days required to achieve sufficient improvement to reduce the frequency of visits for specified conditions is quantifiable. It is our recommendation that you adopt an outside limit of 45 days of daily care. In addition, guidelines for daily visit needs for specified diagnoses within that 45 day visit limit should be established. For example, assuming a 45 day daily visit limit, the range of visit guideline set for stabilizing a complex hospital discharge could be 5 to 7 days.

The Blue Cross/Blue Shield of Colorado has for several years been using diagnostic guidelines referred to as Level I Guidelines to evaluate reasonableness of visit frequency. While these guidelines currently need revision and are sometimes applied arbitrarily by the intermediary, they do serve as a precedent for development of similar guidelines to be used within an outside limit for daily visits. It is further our recommendation that such guidelines provide for individual review of need to go beyond that 45 day limit given unusual circumstances.

As noted above, it is our experience that the need for daily visits is an exception to the norm. Early hospital discharge related to DRG's and avoidance of hospitalization increases the need for this exception to a limited extent. In order to monitor the appropriateness of daily visits, we recommend that the daily visit notes be sent to the fiscal intermediary with all daily visit billing. The Blue Cross/Blue Shield of Tennessee already requires this practice.

We further recommend that the Congress recognize that daily home visits

are a viable option to more expensive hospitalization. The 45 daily visit provision should be allowed in lieu of hospitalization as well as post-hospitalization.

We thank you for the opportunity to make this presentation to you. We appreciate the effort you are making to resolve this issue so that Medicare beneficiaries can receive the scope of services that they need and health care costs can be reduced.

Appendix A

Medicare Bulletin

Blue Cross Blue Shield of Tennessee

August, 1982 Special Home Health Agency Bulletin No. 1

To: All Home Health Agencies

Subject: Daily Home Health Skilled Nursing, Physical Therapy, or Speech Therapy

HCFA has recently clarified the Medicare program policy on daily services with the issuance of Transmittal Number MCR-33-82. It gives the following instructions:

> To qualify for Medicare home health benefits, one of the conditions that must be met is that the skilled services be provided on an intermittent basis. A person who is expected to need more or less full time skilled services over an extended period of time, i. e. a patient who requires institutionalization, would usually not qualify for home health benefits. According to HCFA instructions, services provided as often as five days per week will be considered as daily, and not intermittent. This requirement has been previously outlined in Sections 3116 and 3117 of the Intermediary Manual and Sections 203 and 204 of the Provider Manual. Even though these instructions (Section 3117.1 of the Intermediary Manual and Section 204.1 of the Provider Manual) states that medically reasonable and necessary daily skilled services may be approved for a short period of time (2-3 weeks), medical records must clearly show that the physician intends to decrease the visits in a short time and resume intermittent services. If the medical records do not show an anticipated decrease of visits in the near future, intermediaries have been instructed to make a judgment as to when the need for intermittent skilled services ended and the need for indefinite daily skilled services began. Claims for services on or after that date are to be denied. If a patient requires daily skilled services from the initial visit and daily services are provided because the patient or the family objects to the institutionalization of the patient, the services would not be covered (from the initial start of care) since the need for intermittent skilled services was never established.
>
> Denials based upon the condition that skilled services were not intermittent are considered as technical denials and are not reimbursable to the provider under the Waiver of Liability provision of the Medicare law. Furthermore, since the beneficiary has no way of knowing that daily services are not covered, the beneficiary will not be held liable for the related charges.
>
> Since this bulletin and the provisions as stated in Sections 3116 and 3117 of the Intermediary Manual and Sections 203 and 204 of the HIM-11 (Provider Manual), puts the home health agencies on notice, these denials will not apply to Section 1879 of the Law. Therefore, reconsideration requests by providers on charges denied due to these provisions cannot be accepted.

We will begin applying the above criteria to claims for services rendered on or after September 15, 1982. An exception to the September 15, 1982, date will be those cases for which the provider has received notifications prior to that date.

Appendix B

MEDICARE DIGEST

MEDICARE NEWS AND COMMENTS FOR PARTICIPATING MEDICARE PROVIDERS

Blue Cross. Blue Shield. of Colorado

700 Broadway
Denver, Colorado 80273
303/831-2131

TO: HOME HEALTH AGENCIES FEBRUARY 7, 1983

SUBJECT: MEDICARE REIMBURSEMENT FOR DAILY SERVICES PROVIDED BY A HOME HEALTH AGENCY

Clarification has been received from the Medicare Regional Office on the subject of Medicare reimbursement for daily services provided by a home health agency. Please note that this clarification differs from that information discussed at the December 1982 workshops.

As the law is written, Medicare may reimburse medically reasonable and necessary home health services which are provided on an intermittent basis. However, the intermediary manual does allow for a short period of coverage of both skilled nursing and home health aide services provided on a daily basis. Multiple visits on a daily basis are covered when medically necessary, whether rendered two, three, or four times a day by one or more health worker(s). When the daily services are those of an aide, there must be documentation that a skilled service continues to be required on an intermittent basis.

The manual defines "short period" to be 2-3 weeks but provides that in unusual circumstances, this period may be extended. If daily nursing or aide service is necessary to maintain a patient in his home, the HHA should inform the patient, his family, and his physician that daily services can be reimbursed by Medicare for only a limited period of time. If daily services are expected to be required beyond 2-3 weeks, the HHA should inform the patient (at the onset of daily services, if possible) that Medicare may not pay for the additional services.

Daily services provided to a patient requiring institutionalization when there is not an appropriate bed available cannot be reimbursed indefinitely. As a general rule, the extension of the "short period" (defined above), when warranted by unusual circumstances, should not be for more than a week to 10 days. Slightly longer periods would only rarely be allowed in highly exceptional situations. When the level of care required and rendered by a home health agency on a daily basis is that of a skilled nursing facility or hospital and the patient is not awaiting the availability of a bed, then no home health payments can be made.

Claims denied based on prior interpretation brought to our attention will be reviewed in accordance with these guidelines.

STATEMENT OF MS. EDDIE BERNICE JOHNSON, EXECUTIVE OFFICER, COMMUNITY RELATIONS AND DEVELOPMENT, VISITING NURSES ASSOCIATION OF TEXAS, DALLAS, TX

Ms. JOHNSON. My name is Eddie Bernice Johnson. I'm the executive officer for community relations and development for the Visiting Nurses Association of Texas. I also serve on the Texas Home Health Advisory Council appointed by the Governor of Texas, and a former appointed official of HHS.

The Visiting Nurses Association of Texas serves 11 counties in the north Texas area, and this is our 50th year of continuous service in home health care. I wish to commend you for your interest and thank you for your efforts to help us solve this problem.

The problem of varying and restrictive interpretations of intermittent care by fiscal intermediaries and officials of the Health Care Financing Administration must be resolved. The current statute and regulations use the words "part-time" or "intermittent care for the skilled nursing and home health aide services. This lack of specificity in HCFA's home health manual has led to widely varying interpretations by fiscal intermediaries. This, in turn, has created severe hardship for patients and home health agencies alike.

In Texas, the concensus has been that intermittent care meant less than 8 hours a day. Daily visits when properly documented were allowed. Now, without any change in the statute or regulations, many visits already rendered are being denied for payment. Because these are technical denials, they are not paid under waiver, nor can they be appealed.

And I might say that in the spring of 1983, all the agencies serving in the area where we are lost their waivers with the exception of VNA.

The net effect is to deny care to elderly and disabled persons whom Congress, we feel, intended to receive home health care. Consider these examples:

A 70-year-old male who is a former Braniff employee and had subsequently lost a substantial amount of his pension benefits, has chronic obstructive pulmonary disease. He had a chest tube inserted and was seen by the nurse every other day, per doctor's orders, to change the test tube site dressings. Four days after the start of care, a greenish, foul-smelling discharge began to drain from the chest tube. After 15 days, the doctor ordered daily visits by the nurse. The drainage from his chest tube continued to be purulent and copious, requiring daily dressing changes through a sterile procedure requiring the skill of a health care professional. The patient's wife was unable to handle this procedure, as she gagged and averted her eyes at the smell and sight of the wound. Daily nursing visits continued for about a month until the wound had healed. Yet, 13 skilled nursing visits and 1 home health aide visit were denied for a total of $703 worth of service. Cessation of these daily home care visits would have required institutionalization because without the daily dressing change and skilled observation the patient's condition could have become life threatening.

A second one. A young woman in her late 20's has multiple sclerosis. She lives with her mother and daughter. During periods

when her condition exacerbated, she became bedfast. The VNA provided services in an attempt to aid her in returning to a period of remission, to become stabilized and to remain at home. When she was stabilized, services were terminated. The story does not end here however. Thirty visits totalling more than $1,400 worth of services were denied for payment because they were not considered to be intermittent care, even though the goal of care was to stabilize and discharge the patient.

A wheelchair-bound 68-year-old woman has been able to live alone despite her infirmity. However, she developed an open wound on her tailbone from which a large amount of greenish, purulent discharge drained. The condition of the wound was unstable in that it would continue to alternately improve and then worsen. The patient received 120 visits over an 8-month period, which were denied because these daily visits of about 30 minutes duration were not considered to be intermittent care. The day after the patient's services were discontinued, she was admitted to a nursing home at the doctor's insistence because he said the patient would become septic without daily dressing changes. I might add that skilled nursing facilities cost approximately $1,150.00 a month, twice the $5,000 cost of VNA services over the 8-month period that allowed the patient to remain in her home.

Your support for legislative remedy to clarify the definition of intermittent care for the medicare home health benefit is essential. Senate bill 2338 clearly states that intermittent care includes skilled nursing and home health aide services, with appropriate physician certification, for one or more daily visits up to 60 days. Thereafter, home care may be extended to an exceptional circumstance basis with physician certification.

With this legislative clarification, a consistent national standard would be established. Home health agencies could render daily home health care under appropriate circumstances as intended by Congress without the fear of unpredictable and ever changing interpretations and retroactive denials by fiscal intermediaries.

Thank you very much.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Johnson follows:]

TESTIMONY

OF

EDDIE BERNICE JOHNSON

EXECUTIVE OFFICER

THE VISITNG NURSE ASSOCIATION OF TEXAS

ON BEHALF OF

THE VISITNG NURSE ASSOCIATION OF TEXAS

8200 BROOKRIVER, SUITE 200 N

DALLAS, TX 75247

BEFORE THE

SUB-COMMITTEE ON HEALTH

OF THE

SENATE FINANCE COMMITTEE

HEARING ON

INTERMITTENT CARE

JUNE 22, 1984

Mr. Chairman and Members of the Committee:

My name is Eddie Bernice Johnson. I am the Executive Officer for Community Relations and Development for The Visiting Nurse Association of Texas. I also serve on the Texas Home Health Advisory Council appointed by the Governor of the State of Texas. The Visiting Nurse Association of Texas serves eleven counties in the North Texas area. This is our 50th year of continuous service in home health care.

I wish to commend you for your interest and the indepth study you are giving to an important issue that must be clarified if we are to realize the true cost savings and patient benefits of home care. That issue, of course, is the definition of intermittent care.

The problem of varying and restrictive interpretations of "intermittent care" by fiscal intermediaries and officials in the Health Care Financing Administration (HCFA) must be resolved. The current statute and regulations use the words "part-time or intermittent care" for the skilled nursing and home health aide services. This lack of specificity in HCFA's home health manual (HIM-11) has led to widely varying interpretations by fiscal intermediaries. This, in turn, has created severe hardship for patients and home health agencies alike.

In Texas, the consensus has been that intermittent care meant less than eight hours a day. Daily visits, when properly documented, were allowed. Now, without any change in the statute or regulations, many visits already rendered are being denied for payment. Because these are technical denials, they are <u>not</u> paid under waiver nor can they be appealed.

The net effect is to deny care to elderly and disabled persons whom Congress intended to receive home health care. Consider these examples.

(1) A 70 year old male, who is a former Braniff employee and had subsequently lost a substantial amount of his pension benefits, has chronic obstructive pulmonary disease. He had a chest tube inserted and was seen by the nurse every other day, per doctor's orders, to change the chest tube site dressings. Four days after the start of care, a greenish, foul-smelling discharge began to drain from the chest tube. After 15 days the doctor ordered daily visits by the nurse. The drainage from his chest tube continued to be purulent and copious, requiring daily dressing changes through a sterile procedure requiring the skill of a health care professional. The patient's wife was unable to handle this procedure, as she gagged and averted her eyes at the smell and sight of the wound. Daily nursing visits continued for about one month until the wound had healed. Yet, 13 skilled nursing visits and one home health aide visit were denied for a total of $703 worth of service. Cessation of these daily home care visits would have required institutionalization because without the daily dressing change and skilled observation the patient's condition could have become life threatening.

(2) A young woman in her late twenties has mutliple sclerosis. She lives with her mother and daughter. During periods when her condition exacerbated, she became bedfast. The VNA provided services in an attempt to aid her in returning to a period of remission, to become stabilized and to remain at home. When she was

stabilized services were then terminated.

The story does not end here, however. Thirty visits totalling more than $1,400 worth of service were denied for payment because they were not considered to be intermittent care even though the goals of the care were to stabilize and discharge the patient.

(3) A wheelchair-bound 68 year old woman has been able to live alone despite her infirmity. However, she developed an open wound on her tailbone from which a large amount of greenish, purulent discharge drained. The condition of the wound was unstable in that it would continue to alternately improve and then worsen. The patient received 120 visits over an eight month period which were denied because these daily visits of about 30 minutes duration were not considered intermittent care. The day after the patient's services were discontinued, she was admitted to a nursing home at the doctor's insistence because he said the patient would become septic without daily dressing changes. I might add that skilled nursing facilities cost approximately $1,150 a month, twice the $5,000 cost of VNA services over the eight month period that allowed the patient to remain at home.

Your support for legislative remedy to clarify the definition of "intermittent care" for the Medicare home health benefit is essential. S. 2338 clearly states that "intermittent care" includes skilled nursing and home health aide services, with appropriate physician certification, for one or more daily visits for up to sixty days. Thereafter, home care may be extended on an "exceptional circum-

stance" basis with physician certification. With this legislative clarification, a consistent national standard would be established. Home health agencies could render daily home health care under appropriate circumstances as intended by Congress without the fear of unpredictable and ever changing interpretations and retroactive denials by fiscal intermediaries.

Attempts by the National Association for Home Care (NAHC) to deal with HCFA on the intermittent care issue have been rebuffed. No recourse remains but corrective legislation. With the advent of payment for Medicare patients in a hospital by the use of Diagnostic Related Groups, we expect to see persons in greater need of more intense levels of skilled care in the home. Thus, the problem of intermittent care will undoubtedly become more severe unless Congress addresses this issue.

Thank you, again, for your attention given to this problem.

SUMMARY

The Visiting Nurse Association of Texas, a 50 year old non-profit home health agency serving 11 North Texas counties, urges legislative action to clarify the definition of intermittent care. Interpretations by fiscal intermediaries and the Health Care Financing Administration (HCFA) continue to be both varied and often restrictive, causing severe hardships for health agencies and, more importantly, for their patients. Many home visits are being denied for payments based on new unwritten technicalities which have been introduced without a change in the applicable statute or regulations. Denials under these circumstances clearly do not reflect the spirit of the legislation created by Congress to serve those in need of home health care.

Your leadership in clarifying intermittent care will insure that the spirit of Congress is carried out to serve our citizens in need of quality health care in the home.

37-568 O—84——8

Senator DURENBERGER. I thank all of you for the specificity of your examples.

Let me go back and quote from Ms. Feinstein's statement where she recalls what we thought we were doing in 1980 when we expanded the home health benefit by removing the limit on the number of covered home health visits—"eliminating the requirement for a prior hospital stay, eliminating the deductible and allowing more proprietary home health agencies to participate in the medicare program."

The promises behind these amendments were that the limits were arbitrary; that home health use could substitute for more expensive institutional care; and that proprietary home health agencies were discriminated against by the statutory requirement; that they must be licensed by the State in order to participate in medicare.

Now I guess all that happened for the reasons stated. And rather than read to you the conclusion that follows from that, let me just ask you what went wrong after all those well-intentioned amendments to the law were enacted. And I think that was my second year on this committee.

You don't all have to respond, but maybe somebody can sort of summarize.

Ms. SUTHER. I was in the business at that point in time. One of the major things that happened that was quite a misconception about people ever having received a hundred visits, at that point in time I worked at the South Carolina Department of Health and Environmental Control and had just moved into Atlanta, GA., to the Visiting Nurses Association; there were fewer than 1 percent of all patients that ever received a hundred visits under the medicare benefit.

It was a rare occasion that a patient received a hundred visits because they would be denied, if you provided over 100. And very few even needed 100.

Senator DURENBERGER. Anyone else want to add anything to that?

[No response.]

Senator DURENBERGER. Maybe somebody can just tell me how the home health provider market has changed or has responded to, in effect, the loosening up and expanding the eligibility and some of the requirements. What were the benefits of the 1980 changes?

Sister BRIGIDA. Actually, they have not loosened up. In fact, they have become more restrictive. While that interpretation is there, the fiscal intermediaries may interpret those things any way that they wish. And that is how this intermittent issue has come about. We may have patients who the treatment cannot be completed in 3 weeks. And while it has been said that there is a small rate of denial, the provider does not want to risk losing their waiver and so they will call and ask about this particular patient, and we will get the response that because the patient looks as though—the treatment would last longer than 3 weeks on a daily basis, they must go to a nursing home because home care is not appropriate in this case.

So really the requirements have become more restrictive by interpretation. The law may say that and the Congress' intent was to

liberalize those benefits, but, in fact, it has become more restrictive, I think.

Senator DURENBERGER. And it strikes me—and maybe somebody can confirm or deny this—that it is one thing to say, look, the denials are only a half to 1 percent, nobody is denying anything; and the way I hear you talk about the real world is that since there are no set regulations there is nothing you can look at to find out whether you are in the ball game. It's all sort of loosey-goosey so to speak; when you see just one denial or two denials by your intermediary. And then everybody says, well, I guess that's the rule. Is that the way it has been working?

Ms. MILLS. Senator, what we are doing basically in home care is playing the game by the rules of the intermediary. And if you get a denial, as I did—I have cases pending with administrative law judges now where the patient had 3 weeks of daily visits, and they went back retroactively and denied the entire term of care saying that it was never intended to be intermittent.

So if when you have a few of those, and you learn that you can get paid for 2 weeks of daily visits, you play their game, whether you meet the patient's needs or not. You see the patient for 2 weeks; you go back to the physician and you get orders for three times a week, as I indicated in my previous testimony. And you see the patient for a longer period of time.

But we are forced to play the game by the intermediary's rules.

Senator DURENBERGER. And will you see the same intermediary change the rules of the game from one year to the next?

Ms. MILLS. Oh, certainly.

Ms. SUTHER. From one day to the next.

Ms. MILLS. From one month to the next.

Senator DURENBERGER. Well, what causes that to happen?

Ms. MILLS. Well, our intermediary—I spoke with him many times. They are just refining their interpretation of the regulations. And as they learn more about home care, they are able to make better determinations is the answer I have received.

Ms. SUTHER. Senator, we also have submitted an evaluation model that we would like HCFA to use in evaluating intermediaries because the current tool is a numbers game. There is no inter-intra-observer reliability testing within the intermediaries nor is there any validity, a validating of the tool that they use either in terms of sensitivity or specificity. Assuming that people would do better if they knew how, we submitted an actual model that could be utilized for more scientific and valid evaluation of intermediaries, which has been rejected.

Senator DURENBERGER. Sister Brigida.

Sister BRIGIDA. I feel sorry sometimes for the intermediary because I think they are getting regulated someplace else. And we were told by one of the intermediary representatives; that they were told they should cut their claims back 25 percent. Then they have to be much more detailed in how they review our claims. And where they may have previously told us, yes, you can see this particular patient, when they have to start denying a number of claims arbitrarily, they will cut across some specific claims that we had previously thought we were able to have covered.

Senator DURENBERGER. Yes.

Ms. BOWMAN. There are a couple of comments that I would like to add. One is that several weeks ago I sent to Beth Kuta's staff, to this committee, a ream of documents that the Blue Cross of Tennessee has sent to agencies in the State of Tennessee, which are interpretive of the rules. That set of documents for about a year and a half of time is an inch thick or better than that. And you can see from just that description that we get a substantial amount of redefinition of the rules on a regular basis.

The second observation I would make is that the intermediary manual is different from the provider manual. The language with regard to the intermittent care issue is different from one manual to the other. If you would compare the attachments from some of the intermediaries from the intermediary manual to the attachments that we have provided from the provider manual, you will see that there is, in fact, different language that they deal with and the language that we deal with. So that there are inconsistencies even in the material that is being provided to the two of us who are, in fact, in different ways perhaps, but for are, in fact, responsible for the same realm of patient care and reimbursement relationships.

I would like to have the opportunity with the person who accompanied me to speak to your question, if that would be appropriate too.

Senator DURENBERGER. All right. Just come up and identify yourself for the record.

Ms. ADKINS. I'm Fran Adkins with Health Care Partners, also in Tennessee. I didn't want to speak to that. I wanted to speak a little earlier in regards to your question about how things change.

Senator DURENBERGER. Can you do both?

Ms. ADKINS. What?

Senator DURENBERGER. Can you do both? She wanted you to speak to this question.

Ms. ADKINS. Well, I concur with Rosemary in regards to that question. I think she covered that one thoroughly.

When the 100-visit limit was abolished, that was your question, the change that occurred in Colorado—and I was working in Colorado at that time—was that we did not have to hospitalize the patient at the end of their 100 days, which is what we did and what every other agency in Colorado did to reestablish their eligibility for another 100 days.

Senator DURENBERGER. Let me ask a couple of questions then that that reminds me of in terms of distinctions. Now that we appear to have, at least generally speaking, about half of the people involved here who are referred to home health agencies come from hospitals and about half come fron nonhospital sources, is there any difference in the way reimbursement is handled between those two categories? I see a lot of shaking of heads for the record. The answer is no.

How about is there a difference between hospital based and freestanding home health providers? Are they all experiencing the same kinds of problems? Are they all being treated somewhat similarly? Let me get somebody to react verbally to that.

Ms. BOWMAN. No.

Ms. SUTHER. Our organization represents all auspices free standing, community-based, for profit, not for profit, voluntary, charitable, and health departments, and there is no difference in the way they are handled. We are all treated the same. Based on where we are located, there is a difference, and that's a major difference.

Senator DURENBERGER. Can there be a difference within a community? Let me get it down to that level. Get it down below Tennessee or Texas. Right down to Dallas or Nashville or whatever. Would you find a difference in treatment from one community to another within the same intermediary's jurisdiction?

Ms. SUTHER. Only on occasion within the same intermediary's jurisdiction. We have a patient which was discharged from our agency because we could not provide the service; our intermediary would not allow it. They went to another agency that had another intermediary because they were a chain organization and chain organizations are frequently allowed to have an intermediary in another State, the service was covered.

Senator DURENBERGER. All right. So the problem here then will be as between intermediaries. The New York versus whatever.

Ms. MILLS. Yes. It's the interpretation of the intermediary.

Senator DURENBERGER. Let me ask you one other question. What happens to the people involved here? I mean after the denial or when you know ahead of time, what happens to the human beings involved in the system? How do they finance an alternative to home health care or do you continue them even though there has been a denial of service?

Ms. JOHNSON. They are normally institutionalized by nursing homes or hospitals, which is much more costly, and many times that level of care is unnecessary.

Ms. SUTHER. Or the community-based voluntary agency that has some charitable funds may take this out of the charitable fund and bankrupt the charitable fund. In fact, in our agency we did just that last year. We had a tremendous deficit as a result of the denials, and we did experience a tremendous deficit for the last 2 years as a result of that.

Ms. MILLS. Many times, Senator, the care has already been rendered and the patient has been discharged before the agency is notified of denial so that the patient has received that care whether the agency has ever paid for it or not.

Ms. ADKINS. In addition to that, if a patient doesn't realize how sick they are, they may just go on and not get institutionalized and then they get sicker and then they die. I would concur with what the lady next to me said regarding the fact that we have probably already done the care for 3 or 4 months after that because it's generally 3 or 4 months before we get the denial after the care is delivered anyway.

Senator DURENBERGER. Yes.

Ms. ADKINS. And then the denial process or the rebuttal of the denial process takes anywhere from 3 to 6 months or longer, if you are in Colorado, right now, and we are not sure when they are ever going to get to the rebuttal. And the patient just hangs in limbo and really can't receive home care services for that condition until it is resolved. And it may be a year before it is resolved.

Senator DURENBERGER. This whole afternoon is illustrating the problem of the Government trying to be an insurance company. It's a great frustration. Now before we get out of the business, though, we do have to deal with these people, and we are trying to put cost effective incentives in place. And it seems to me that the one thing you can agree with HCFA on, at least as I heard Patrice testify, is that there is a value and some flexibility in the treating of each person as an individual. And or one community might be somewhat different from another, depending upon the other related sources that might be in that community. So there is some value in some flexibility and some discretion.

And yet you seem to be in the process of finding and overcoming the problems with discretion, saying if you take the discretion away, we want some rules. Am I misinterpreting what I am hearing?

Ms. BOWMAN. Well, I think that from our point of view is if there is an assumption of flexibility in judgment then we would like to have that assumption passed down to the intermediaries because our experience is that they are not using a notion of flexibility. They are using absolute. They are saying 3 weeks is it and that is all you get.

Our experience has been that we have, with our Denver agency, we have gone to the intermediary prior to the end of the third week of daily visits and said this is what is going on, this is what we need to do, we expect to need another week of daily visits. And in one instance the intermediary said OK. When we sent in the billing, the intermediary denied the extra visits.

You know, not only did we get no flexibility, we got no cooperation after the OK had been given. I think the issue is—if, in fact, HCFA is supposedly dictating flexibility, if that is not a contradiction, then we would like to see that flexibility apply. If there is to be no flexibility, then give us some absolute outside limits that we know about and we will work within those.

Senator DURENBERGER. Now one of you—maybe it was Ms. Suther in her opening statement—said something good about one of these provisions on what the conferees did last night on 4170. And if I have this correctly, it said the conferees direct the Secretary to clarify existing policy and provide for its uniform implementation. That makes a lot of sense.

This should be more easily accomplished under a separate provision agreed to by the conferees, suggested in the House offer, which provides for moving within 3 years to no more than 10 regional home health intermediaries rather than 47 as now provided for under current policy. Somebody said that was a good idea? Oh, Patrice said that. She thought it was a good idea. All right. [Laughter.]

Senator DURENBERGER. Now the light went on. It strikes me that moving to 10 just makes the problem 4.7 times as bad and that we would be much better off if we moved in the direction of having the intermediary as close as possible. And if there were a way at the beginning of the year or in advance of a year or something like that for the people in Tennessee or in the Nashville area or something like that to, in effect, come up with a plan of some kind, that this is the way we are going to reimburse for these kinds of serv-

ices during the course of this year, and have the intermediary say, yeah, that looks like it meets the rule. Fine, you have got an approved plan and you all operate under that.

I'm not suggesting that's what we ought to do. I'm trying to think of an alternative to the rules and regulations that has in it some degree of flexibility. If there were an agreement ahead of time for a year or a 2-year period of time that here is the way we are going to operate and this is what the rules are going to live by. Does that make any sense?

Ms. SUTHER. There is one thing we failed to mention and that is that most intermediaries do not have any—standards, professional standards, for the persons reviewing the claims. In some instances, a dentist may be reviewing medical claims or a nurse who has never worked a day in her life, with no clinical experience. That kind of thing. So that's another thing that adds to the problem that we have.

Senator DURENBERGER. Well, I'm just trying to move away from reviewing every single claim, having a dentist reviewing it, or whatever you were talking about there, to pre-qualifying the way the relationship is going to exist in that particular community. And then all you have got to make sure is that somebody actually went into the home and was there. You don't have to necessarily spend a lot of time on the appropriateness.

Ms. SUTHER. A PSRO, from an outside group, might accomplish that.

Senator DURENBERGER. All right. Anybody given any thought to prospective payment? You all want to endorse expanding the DRGs to include everything next year? [Laughter.]

Mr. SUTHER. We would hope that you would look at prospective payment in light of not only diagnostic category but functional disability, age and living status and many other factors because in home care, diagnosi is not the major reason that a person needs care.

Senator DURENBERGER. Yes, Sister.

Sister Brigada. We would also hope that something like the ABT study would be completed before something like that would be implemented because we really don't have a firm data base for the varieties of home care that have emerged with this, as I was trying to point out, modern technology. And we need better data. And in some of the things that Mary was pointing out, the variables in home care are not just disease categories. There may not be a support person in the home, the age of the patient and so forth. And we don't have enough of a handle on that to tell how that payment should be determined.

Senator DURENBERGER. Just for the record and so you will know where I stand, I am very hopeful that we can move this prospective system. And eventually, as I said earlier, I hope we get to the vouchers as quickly as possible so we get out of this game entirely. And then let people who are experts do all this sort of stuff.

But I would really be very helpful that we do this in two stages. One is to authorize it, and the second is to implement. Then the more support we can get from home agencies for at least authorizing a prospective payment, that includes the doctors and home health and skilled nursing facilities as well as hospitals, the better.

But if we stage its implementation based on when we have the information in hand, I just fear that some people are going to say, well, we don't have enough information so let's not even authorize it. And we will be around here in 1987 and 1988.

If you think what you perceive to be HCFA dollar pressures are bad today, wait until 1985 and 1986. Just wait until 1985. It's not an election year. This year we had the nerve to cut—I don't know what they will end up cutting, but there was at least the will to do about $8 billion a year of cutting out of medicare this year. Now if politicians have the will to do that in an election year, they will really cut in a nonelection year.

What some of us are struggling for is to stop the cutting and move to a greater use—or better use—of these health care dollars. And I think we see that a prospective payment system as an interim to a voucher system that will give people the flexibility to make those decisions. So the more help you can be, the better.

Ms. ADKINS. I have a suggestion regarding DRG's for home care. And that is that a system be developed based on nursing diagnosis rather than medical diagnosis for home care, seconding what these other ladies are saying. There is a distinct difference.

I think, as the slide showed, that difference very well in that we are teaching somebody to do a nursing procedure and that person may be very frightened. The procedure may be very repulsive and there may a very strong odor that most people can't tolerate. And we have to teach that person to cope with those things as well as do the procedure. And if you just say a wound, I can go in and do a wound like that, but to teach that person in that slide to do that wound is another thing, if they have particular problems in doing that.

Senator DURENBERGER. Please don't forget the chaplain services. In other words, when you are talking about hospital DRG's. I mean there is, in part, a mental health and a spirituality and a lot of other things involved in health care. It's hard to sit here and factor *X* number of dollars for spiritual advice, but most of you who are in the business know that there is a component like that also.

I thank you all very much for your testimony. I appreciate it a lot.

Senator DURENBERGER. Our next panel will be Mr. Merritt Jacoby, executive director, Medicare Part A Administration, Blue Cross and Blue Shield Association; Mr. John R. Anderson, director, Provider and Professional Relations and Medicare Administration, Blue Cross and Blue Shield of Connecticut; Mr. Rufus Williamson, Blue Cross of Tennessee; Kathryn St. Germain, Director of Alternative Health Plans for Blue Cross of California.

You have all been here for the last hour or so, and I shouldn't have to ask you any questions. Your prepared statements will be made a part of the record. And you can clarify for this committee all of the things, the inconsistencies, if you will, between what we heard from HCFA and what we heard from the health care providers.

And we will start with Mr. Jacoby.

STATEMENT OF MERRITT JACOBY, EXECUTIVE DIRECTOR, MEDICARE PART A ADMINISTRATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL

Mr. JACOBY. Mr. Chairman, my remarks will be introductory to three people who have come with me and who operate and manage medicare intermediary functions in those states.

I think it's well known that the Blue Cross and Blue Shield Plans are and have been heavily involved in medicare administration, and we would like to also have it known that we are committed to cost effective and sensitive administration of the program.

Since the beginning of the program, the Association has been a major fiscal intermediary, providing Medicare services through subcontracts with the local Blue Cross Plans to process the claims and audit and reimburse the providers.

These functions require that the plans apply medicare policy as it is set forth in the law, the regulations and the program instructions which we receive from the Health Care Financing Administration.

We commend this subcommittee for taking the opportunity to review these aspects of the medicare home health benefit. In our private business, we are extensively involved in providing coverage for home health services where they are shown to be cost effective as an alternative to inpatient care. With respect to medicare, the subcontracting Blue Cross Plans perform regional intermediary functions for home health agencies in 45 States and the District of Columbia.

Our comments today will focus on the issue of skilled nursing services to be provided on a part time or intermittent basis in order for these and other health services to be covered. Over the last few years, as has been demonstrated by this hearing today in the remarks made so far, the interpretation of intermittent care requirements has become even more important to the cost effective administration of home health benefit because of the removal in July 1981 of limits on the number of visits that can be covered under medicare.

For many years, our Association has been working closely with HCFA in its effort to clarify the definitions and guidelines that are needed to apply this requirement and eliminate some of the confusion. We believe that HCFA has made progress in clarifying these guidelines over the years. Further clarification, we believe, is also necessary and we understand from some of the earlier testimony today that further guidelines and definitions will be forthcoming. They are needed if the variations in the interpretation of the guidelines by intermediaries are to be minimized. We are confident that improvements in the administration of this benefit can be made through cooperative efforts of HCFA, the intermediaries and the home health agencies. And we are hopeful that today's hearing will provide additional insights into this benefit that will help us to all make those improvements.

At this point, Mr. Chairman, I would like to refer to Mr. Williamson from Tennessee.

[The prepared statement of Mr. Jacoby follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

BEFORE THE

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

PRESENTED BY

MERRITT JACOBY

EXECUTIVE DIRECTOR

MEDICARE PART A ADMINISTRATION

JUNE 22, 1984

Mr. Chairman and members of the Subcommittee, I am Merritt Jacoby, Executive Director of Medicare Part A Administration for the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield Plans are heavily involved in Medicare and we are deeply committed to the cost effective administration of the program.

Since the beginning of the Medicare program, the Blue Cross and Blue Shield Association has served as a major fiscal intermediary, providing claims administration, provider audit and reimbursement, and related services for Part A of Medicare — Hospital Insurance. Through subcontracts with the Association, local Blue Cross and Blue Shield Plans process claims, audit and reimburse providers. These functions require the Plans to apply Medicare policy as it is set forth in the law, regulations and program instructions.

We commend the Subcommittee for taking this opportunity to review the complex and difficult issues relating to the Medicare home health benefit. In our private business, we are extensively involved in providing coverage for home health care services where they are shown to be a cost-effective alternative to inpatient care. With respect to Medicare, subcontracting Blue Cross and Blue Shield Plans perform regional intermediary functions for home health agencies in 45 states and the District of Columbia.

Our comments today will focus on the Medicare requirement that skilled nursing services be provided on a part-time or intermittent basis in order for these and other home health services to be covered. Over the last few years the interpretation of the intermittent care requirement has become even more important to the cost-effective administration of the home health benefit because of the removal in July 1981 of the limits on the number of visits that can be covered under Medicare.

For many years, our Association has worked closely with HCFA in its efforts to clarify the definitions and guidelines that are needed to apply this requirement. We believe that HCFA has made progress in clarifying these guidelines over the years. Further clarification will, however, be necessary if variations in the interpretation of the guidelines by fiscal intermediaries are to be minimized. We are confident that improvements in the administration of the Medicare home health benefit can be made through the cooperative efforts of HCFA, the intermediaries, and the providers, and we are hopeful that today's hearing will provide additional insights into this difficult area that will help us make these improvements.

With me today are representatives from Blue Cross and Blue Shield of Connecticut, Blue Cross and Blue Shield of Tennessee, and Blue Cross of California, who will describe their experiences in applying the intermittent care requirement.

Senator DURENBERGER. Before Mr. Williamson speaks, are there any other areas besides the intermittent care requirement that are causing similar and substantial differences of opinion between intermediaries and providers?

Mr. JACOBY. I would think that there are two that come to mind. And perhaps some of those folks that are with me can expand on that. Home-Bound definition is an area, which I understand, causes difficulty. And I think an underlying problem that we struggle with in administering this benefit is the great difficulty people have in understanding that the program has structure and definition, qualifying factors which determine when a benefit will be provided, and how long it will be provided. There are, in other words, limits. You then have situations where, as I think we have heard today, you have situations where a patient needs care. There is no question. They need the care. But what they encounter is a structure in a benefit program which is necessary in any benefit program for control that is not understood. It is viewed as an improper restriction or denial simply because the program was not designed to pay under those particular conditions.

Senator DURENBERGER. All right.

STATEMENT OF RUFUS WILLIAMSON, VICE PRESIDENT, GOVERNMENT CLAIMS, BLUE CROSS AND BLUE SHIELD OF TENNESSEE

Mr. WILLIAMSON. I am Rufus Williamson, vice president of Government claims for Blue Cross and Blue Shield of Tennessee, one of the medicare part A subcontractors to the Blue Cross Association.

In Tennessee we currently have 252 certified home health agencies. And I am told that by the end of the year we will have about 400. So we do currently have more certified agencies in Tennessee than any other State.

Senator DURENBERGER. Why is that?

Mr. WILLIAMSON. Why is that?

Senator DURENBERGER. Are you a generous intermediary?

Mr. WILLIAMSON. Apparently so. [Laughter.]

I think it is that we have not had a certificate of need law until very recently. It was signed, I believe, last week by the Governor, with the support of the home health association agencies.

Senator DURENBERGER. So what has that got to do with it? You mean that will cut down?

Mr. WILLIAMSON. That will cut down the new application for home health agencies in the State of Tennessee.

Senator DURENBERGER. All right. I'm sorry I interrupted you.

Mr. WILLIAMSON. Home health care has been proven over a period of many, many years to be a safe and cost effective alternative to expensive inpatient care. I think the key thing that we need to remember, though, is that in order to be optimally cost effective, it must be intermittent and not on a daily basis.

Just for example, in fiscal year 1983, the cost for 30 days of continuous care in a skilled nursing facility was $1,290.00. That's for a full 30 days. The cost for 30 days of continuous visits by a home health agency was $1,538.00, which is substantially higher.

Senator DURENBERGER. Do you have a certificate of need for skilled nursing facilities in Tennessee also? Or do you have a moratorium on construction of nursing facilities?

Mr. WILLIAMSON. There has been no construction. I understand there will be some new constructions generated. I do not believe there is currently a certificate of need for that particular type of facility unless it is hospital based.

I would point out that the current guidelines provided to intermediaries by the Health Care Financing Administration defining intermittent for purposes of claims administration is also published in the home health agency manual. And as part of my testimony that has been submitted to the committee, the intermediary manual and the home health agency manual material is reproduced and the wording is identical in the two.

There are two basic conditions that must be met to qualify if the care is intermittent. First, the care must be for a medically predictable recurring period of at least 60 days. And, second, the care must not be required on a daily basis except for a short time. There has been quite a bit of testimony on that.

The key elements of information needed by the intermediary to determine whether to pay a claim are, first, the patient's condition, and, second, the length of time the services will be provided, if it's a claim for daily care. So it's a matter really of communication.

And I would also reiterate what has been mentioned by some of the other people today, that there are not a lot of denials for intermittent care. In Tennessee, most agencies have never received a denial for intermittent care problems. In fact, the total number of denials is fairly low, and only a very small portion of the denials is for intermittent care.

In our experience in Tennessee, the current guidelines are considered to be adequate and appropriate in administering the home health benefit of medicare. If there are perceived inconsistencies in administration, this is primarily due to the differences in individual cases rather than misunderstood guidelines.

Senator DURENBERGER. So the summary is that everything is hunky-dory in Tennessee and Ms. Bowman is out of her tree. [Laughter.]

Now I am missing something here.

[Laughter]

Mr. WILLIAMSON. No. I don't think Ms. Bowman actually said there was a major problem in Tennessee. She emphasized what some of the other folks had said. There are some people, obviously, that are not getting daily care that may need it. But I believe it's more cost effective to take care of these patients in a skilled nursing facility that is available to do this type of care at a lower cost.

Senator DURENBERGER. So what Mr. Jacoby was saying earlier about benefit structure not conforming to everybody's understanding of what their particular needs are and what sort of a facility can best satisfy those needs, you are saying is the—that's sort of a major problem.

Mr. WILLIAMSON. Yes.

Senator DURENBERGER. Thank you.

[The prepared statement of Mr. Williamson follows:]

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD OF TENNESSEE

BEFORE THE

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

PRESENTED BY

RUFUS WILLIAMSON

VICE PRESIDENT, GOVERNMENT CLAIMS

JUNE 22, 1984

Mr. Chairman, I am Rufus Williamson, Vice President of Government Claims at Blue Cross and Blue Shield of Tennessee, the Medicare Part A subcontractor to the Blue Cross and Blue Shield Association for the State of Tennessee. In Tennessee, we have currently certified 252 Home Health Agencies with 30 more expected by the end of the year. Governor Alexander has just signed a certificate of need law that was supported by the State Home Health Association to reduce new agency applications.

Because we have more agencies in Tennessee than any other state at the present, we have an opportunity to deal first hand with a number of issues about which the committee is concerned. We have areas in the state where there are more than enough agencies to serve the available clients, while other areas have barely enough participating agencies to meet the demands for services.

Home health care has a long history of effective service in several areas of the country and is currently a safe and cost effective alternative to expensive inpatient care in Tennessee. When operated as an integral part of the health care system, there are several advantages to the use of this form of care including lower cost and the beneficial effect of familiar surroundings of home on recovery of the patient. A medical decision is needed to determine the point in time at which home care is the treatment of choice from the perspective of safety and efficiency.

In order to optimally fulfill the goal of cost effectiveness, home health care must be rendered on an intermittent basis, not on a continuing daily basis. The following statistics for FY 1983 illustrate that continuous home health care provided on a daily basis is not a cheaper alternative to institutional care in Tennessee:

Cost of 30 days continuous care in a skilled nursing facility - $1,290.60

Cost of 30 days consecutive visits by a home health agency - $1,538.32

These home health statistics are derived from historical data and are subject to variation by agency and state.

The current guidelines provided to intermediaries by the Health Care Financing Administration (HCFA) defining "intermittent" for purposes of claims administration, including those issued by the HCFA regional office in Atlanta, are provided for the record in their entirety. In summary, the guidelines specify two basic conditions that must be met to qualify the care as intermittent. First, the care must be for a medically predictable recurring need, i.e., at least once every 60 days. Second, the care must not be required daily except for a short time, i.e., no more than 2-3 weeks. Intermediaries rely on the orders written by the physician to determine if the required conditions have been met.

The key elements of information needed by the intermediary to determine whether to pay a claim are the patient's condition and the length of time services will be provided if the claim is for daily visits. If the agency does not remind the physician of the need to provide this data and if the daily visits extend beyond 2-3 weeks, the care is deemed not intermittent and the claim is rejected.

On the other hand, if the order is for 2-3 weeks and the patient needs a brief extension, the physician must evaluate the patient at the end of his previous order anyway and provide the home health agency with additional documentation for the patient's further needs. If daily care is needed for an indefinite period, the home health agency would be advised by the intermediary that the period after the first order would not be covered.

37-568 O—84——9

The guidelines cited above are provided to the home health agencies in the Medicare Home Health Agency Manual (HCFA-Pub. 11) as well as in various intermediary publications and in training workshops. Most agencies in Tennessee do not have any claims rejected for this reason. The few claims that are rejected for this reason are likely the result of agency error in not carefully evaluating the patient or in not working with the physician to properly document the case.

In our experience in Tennessee, the current guidelines are adequate and appropriate in administering the home health benefit of Medicare. If there are perceived inconsistencies in administration, this is primarily due to the differences in individual cases rather than in misunderstood guidelines.

Medicare Bulletin

Blue Cross Blue Shield of Tennessee

August, 1982 Special Home Health Agency Bulletin No. 1

To: All Home Health Agencies

Subject: Daily Home Health Skilled Nursing, Physical Therapy, or Speech Therapy

HCFA has recently clarified the Medicare program policy on daily services with the issuance of Transmittal Number MCR-33-82. It gives the following instructions:

> To qualify for Medicare home health benefits, one of the conditions that must be met is that the skilled services be provided on an intermittent basis. A person who is expected to need more or less full time skilled services over an extended period of time, i. e. a patient who requires institutionalization, would usually not qualify for home health benefits. According to HCFA instructions, services provided as often as five days per week will be considered as daily, and not intermittent. This requirement has been previously outlined in Sections 3116 and 3117 of the Intermediary Manual and Sections 203 and 204 of the Provider Manual. Even though these instructions (Section 3117.1 of the Intermediary Manual and Section 204.1 of the Provider Manual) states that medically reasonable and necessary daily skilled services may be approved for a short period of time (2-3 weeks), medical records must clearly show that the physician intends to decrease the visits in a short time and resume intermittent services. If the medical records do not show an anticipated decrease of visits in the near future, intermediaries have been instructed to make a judgment as to when the need for intermittent skilled services ended and the need for indefinite daily skilled services began. Claims for services on or after that date are to be denied. If a patient requires daily skilled services from the initial visit and daily services are provided because the patient or the family objects to the institutionalization of the patient, the services would not be covered (from the initial start of care) since the need for intermittent skilled services was never established.
>
> Denials based upon the condition that skilled services were not intermittent are considered as technical denials and are not reimbursable to the provider under the Waiver of Liability provision of the Medicare law. Furthermore, since the beneficiary has no way of knowing that daily services are not covered, the beneficiary will not be held liable for the related charges.
>
> Since this bulletin and the provisions as stated in Sections 3116 and 3117 of the Intermediary Manual and Sections 203 and 204 of the HIM-II (Provider Manual), puts the home health agencies on notice, these denials will not apply to Section 1879 of the Law. Therefore, reconsideration requests by providers on charges denied due to these provisions cannot be accepted.

We will begin applying the above criteria to claims for services rendered on or after September 15, 1982. An exception to the September 15, 1982, date will be those cases for which the provider has received notifications prior to that date.

HCFA PROGRAM ISSUANCE
Transmittal Notice
REGION IV

DATE: June 9, 1982 PROGRAM IDENTIFIER: MCR-33-82 (PO)

Of Interest to Intermediaries

SUBJECT: Claims for Daily Home Health Skilled Nursing Services

We were recently asked by an intermediary if daily skilled nursing visits rendered by a home health agency beyond the period of time discussed in section 3117.1 of the Intermediary Manual should be denied because the patient was receiving "above a home health level of care." The intermediary related two examples. One was a case where from the initial home health visit, daily skilled nursing services were rendered because the patient and his family objected to the patient's being institutionalized. A second example involved a patient who initially received intermittent skilled nursing services but then began receiving nursing services on a daily basis. The daily visits continued beyond the period of time discussed in section 3117.1 of the Intermediary Manual and it appeared the daily services would continue indefinitely.

The intermediary denied claims in both situations reasoning that each of these patients needed institutionalization not home health care. After relating these examples to our Central Office, we were informed the claims for these services should have been denied but not because the patients were receiving "above a home health level of care." Rather, as discussed in section 3117 of the Intermediary Manual, one of the conditions which must be met before reimbursement can be made for skilled nursing services in the home is that the services be required on an intermittent basis. In each example the fact that condition was not met provides the basis for denial.

In the first example the services are not covered (from the initial start of care) since the need for intermittent nursing services was never established. In the second situation the physician twice extended his estimate of the length of time the patient would require daily skilled nursing services in accordance with Section 3117 of the Intermediary Manual. However, since there was no sign the need for daily skilled services would end, the intermediary had to make a judgement as to when the need for intermittent skilled services ended and the need for indefinite daily skilled services began. Claims for services furnished on or after that date are not covered.

We expect that other cases like the two discussed above will arise. Since such cases involve sensitive and complex medical considerations, they should all be carefully reviewed by an intermediary's medical consultant. Again, the basis for any resulting denials should be that a beneficiary no longer needs intermittent skilled nursing services as required by sections 1814(a)(2)(D) and 1835(a)(2)(A) of the statute and sections 405.170 and 405.1633 of the regulations, not that s/he needs "above a home health level of care."

If you have questions concerning this issue, please contact George Songer at (404) 221-2407.

George R. Holland
Regional Administrator
Division of Program Operations

Assuming that all the above conditions and all the other requirements for home health benefits are met, reimbursement can be made under the program for the skilled nursing care required by a beneficiary without regard to whether the beneficiary had a terminal, chronic, or acute illness, his or her condition is stabilized or unstabilized, or the need for skilled nursing service may extend over a long period of time.

However, since many individuals with stabilized or chronic conditions and possibly at some stage of their illnesses, individuals with terminal conditions, require only the services of a home health aide, the intermediary should assure that the skilled nursing care prescribed (as well as any other covered service they may receive) is reasonable and necessary to the treatment of the illness or injury. (See § 3117.3)

3117.1 Definition of "Intermittent".-- To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

Since the need for "intermittent" skilled nursing care makes the individual eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling silicone catheter who generally needs a catheter change only at 90-day intervals;

2. The person who experiences a fecal impaction due to the normal aging process (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or

3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed, thus supplementing the physician's contacts with the patient. (See Coverage Issues Appendix, § 90-1.)

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be reimbursable. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem which would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in § 3119.6) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3 week period, the home health agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time; i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

3117.2 Reimbursable Skilled Nursing Care.--Reimbursable skilled nursing care consists of those services reasonable and necessary to the treatment of an illness or injury (see § 3117.3) which must be performed by or under the direct supervision of a licensed nurse (R.N. or L.P.N. or L.V.N.) if the safety of the patient is to be assured and the medically desired result achieved. (See § 3117.4E2 and § 3117.5 for special exceptions.)

A. In determining whether a service requires the skill of a nurse, consideration must be given to both the inherent complexity of the service and the condition of the patient.--In many instances a service may be classified as a skilled nursing service on the basis of its complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters. (See §§ 3117.4H.1 and 3117.4E.) In others the classification will require a consideration of both the nature of the services and the condition of the patient, i.e., in a given case the patient's condition may be such that a service which would normally be classified as unskilled can only be provided safely and effectively by a skilled individual. For example, it is possible that in some situations a patient who has had rectal surgery may be given an enema safely and effectively only by a nurse.

B. The services are required on an intermittent basis (see § 204.1);

C. The services must be performed by or under the direct supervision of a licensed nurse (R.N., L.P.N., or L.V.N.) to assure the safety of the patient and to achieve the medically desired result (see § 204.2); (see § 204.5 for exception in the case of services by student nurses); and

D. The services are reasonable and necessary to the treatment of an illness or injury (see § 204.3).

Assuming that all the above conditions and all the other requirements for home health benefits are met, reimbursement can be made under the program for the skilled nursing care required by a beneficiary without regard to whether the beneficiary had a terminal, chronic, or acute illness, his or her condition is stabilized or unstabilized, or the need for skilled nursing service may extend over a long period of time.

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204.1 Definition of "Intermittent".-- To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

Since the need for "intermittent" skilled nursing care makes the individual eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

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Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be reimbursable. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem which would require this service is not medically predictable.

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B. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where the nature of a service is such that it can be safely and

STATEMENT OF MR. JOHN R. ANDERSON, DIRECTOR, PROVIDER AND PROFESSIONAL RELATIONS AND MEDICARE ADMINISTRATION, BLUE CROSS AND BLUE SHIELD OF CONNECTICUT, INC.

Senator DURENBERGER. Mr. Anderson.

Mr. ANDERSON. Chairman Durenberger, my name is John Anderson of Oxford, CT, director of provider and professional relations and medicare administration for Blue Cross and Blue Shield of Connecticut, the medicare part A subcontractor for Blue Cross and Blue Shield Association since the inception of the program in 1966. In this capacity, we have serviced the State's 107 home health agencies for the past 3 years.

Our experience in performing intermediary functions has demonstrated that much more severely ill patients are being maintained at home for longer periods of time, but the present medicare benefit is not adquate to accommodate their medical needs.

The present home health benefit provides coverage for part-time or intermittent services of skilled personnel and home health aides. Intermittence by definition means: a medically predictable recurring need for a skilled service at least once every 60 days; however, the care needs of the more severely ill patients I referred to usually entail daily intervention by agency personnel. Since the home health benefit was initially structured to provide for services a few hours a day, several times a week, the current mechanism is inadequate to sustain these patients whose needs are for daily care.

There is an exception to this intermittent requirement which allows for coverage for daily care for short periods of time, under unusual circumstances. However, it is this exception which has created the inconsistent and confusing guidelines for administering the home health benefit.

Much of the confusion, I believe, began with the release of a March 1982 home health agency manual policy revision in Connecticut. This modification was interpreted much more liberally by the provider community. Increased volumes of claims for daily services were submitted to the program, and as a result a more intensified review process was implemented by intermediaries. Increased medical screening activities precipitated more denials of benefits and patient advocate groups and beneficiaries sought the help of legal assistance groups to remedy the situation.

The problem is intensified since many medicaid and private insurance programs do not reimburse for the level of intensified care needed by these patients. As a result, beneficiaries must pay out of pocket. The alternative of institutionalization in skilled nursing facilities would hardly seem compatible with current medicare cost containment initiatives, nor is it likely that an expansion of the SNF benefit would provide a solution since many home health beneficiaries fall between the cracks between SNF and home health agency care.

The only other alternative would be to modify the level of care guidelines to expand the period of coverage for daily care. While I believe that most of the problem in Connecticut would be alleviated by this approach, cost to the medicare program would definitely be increased.

Thank you.

Senator DURENBERGER. Thank you very much.
[The prepared statement of Mr. Anderson follows:]

TESTIMONY OF BLUE CROSS & BLUE SHIELD OF CONNECTICUT, INC.

BEFORE THE UNITED STATES SENATE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

CONCERNING THE MEDICARE HOME HEALTH BENEFIT

JUNE 22, 1984

REMARKS BY JOHN R. ANDERSON

DIRECTOR, PROVIDER AND PROFESSIONAL RELATIONS AND

MEDICARE ADMINISTRATION

Chairman Durenberger and Members of the Subcommittee; my name is John R. Anderson of Oxford, Connecticut. I am Director of Provider & Professional Relations and Medicare Administration for Blue Cross & Blue Shield of Connecticut, the Medicare Part A subcontractor for the Blue Cross and Blue Shield Association since the inception of the program in 1966. In this capacity, we have serviced the state's 107 Home Health Agencies for the past three years.

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The present home health benefit provides coverage for part-time or intermittent services of skilled personnel and home health aides. Intermittence by definition means: a medically predictable recurring need for a skilled service at least once every sixty days; however, the care needs of the more severely ill patients I referred to usually entail daily intervention by agency personnel. Since the home health benefit was initially structured to provide for services a few hours a day, several times a week, the current mechanism is inadequate to sustain these patients whose needs are for daily care.

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by the provider community. Increased volumes of claims for daily services were submitted to the program, and as a result a more intensified review process was implemented by intermediaries. Increased medical screening activities precipitated more denials of benefits and patient advocate groups and beneficiaries sought the help of legal assistance groups to remedy the situation.

The problem is intensified since many Medicaid and private insurance programs do not reimburse for the level of intensified care needed by these patients. As a result, beneficiaries must pay out-of-pocket. The alternative of institutionalization in skilled nursing facilities would hardly seem compatible with current Medicare cost containment initiatives, nor is it likely that an expansion of the SNF benefit would provide a solution since many home health beneficiaries "fall through the crack" between SNF and home health requirements.

The only other alternative would be to modify the level of care guidelines to expand the period of coverage for daily care. While I believe that much of the current problem that we see in Connecticut would be alleviated by this approach, it also would likely increase costs to the Medicare program.

I would be happy to answer any questions that member of the subcommittee would have at this time.

STATEMENT OF KATHRYN ST. GERMAIN, DIRECTOR OF ALTERNATIVE HEALTH PLANS, BLUE CROSS OF CALIFORNIA

Senator DURENBERGER. Ms. St. Germain.

Ms. ST. GERMAIN. Senator, I'm Kathryn St. Germain, director of alternative health plans of Blue Cross of California. Blue Cross of California has been a subcontractor to the medicare part A intermediary for the last 18 years in home health. We believe that the current regulations offer the intermediary adequate latitude in determining covered care for intermittent services that may be necessary on a daily basis for a 2- to 3-week period and sometimes beyond.

We define covered care on a daily basis as rendered when services are provided with the skills of a nurse, services are medically necessary and do not duplicate services provided by others. There is evidence of monitoring by a physician as to continual need for services, and new orders are written should the care extend beyond the 21 days. Intermittent care extends itself to daily and sometimes more frequently because we find in California that patients are being discharged very much sooner and are very much sicker. Skilled home care services are often of a higher level than those provided in skilled nursing facilities. There is in California also a shortage of skilled nursing beds, and many skilled nursing facilities refuse to take these patients because of the intensity of the services that they need.

We conducted a study, and while we don't pretend that we did a statistical sampling or used any scientific method—but we did earlier in 1983 for the months of February and March look at all of our home health bills that were billed for daily care services. What we found in those bills is that the skilled daily care was rendered to patients recently discharged from hospitals, home care was less costly to the medicare program than institutional care even when rendered on a daily basis, care in the majority of these cases became less intensive within the 21-day timeframe, both due to the change in the patient's condition and also because of the educational activities given to others in the home.

We have conducted a number of compliance audits and have found that the home health agency has been able to demonstrate the medical necessity for the daily care, although that doesn't mean we have never found any compliance problems issues in terms of home health. But where we found them is in billing errors or the home health agency keeping the patient in the program too long on intermittent or 3 times a week rather than daily service, and the care has become at the end of the plan of treatment a custodial care issue.

We utilize many screening and medical review procedures so that we are able to monitor the intermittent care closely and effectively. We believe that the care that is provided and monitored in the State of California for home health service benefits, that these benefits truly operate as an instead-of type service rather than an add-on benefit to the medicare program.

And we also believe, again, that present regulation allows us to make these determinations appropriately.

[The prepared statement of Ms. St. Germain follows:]

TESTIMONY

OF

BLUE CROSS OF CALIFORNIA

BEFORE THE

SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

PRESENTED BY

KATHRYN ST. GERMAIN

DIRECTOR OF ALTERNATIVE HEALTH PLANS

BLUE CROSS OF CALIFORNIA

JUNE 22, 1984

Good afternoon Senator Durenberger, Members of the Subcommittee.

My name is Kathryn St. Germain and I am Director of Alternative Health Plans for Blue Cross of California.

I wish to thank you for allowing Blue Cross of California the opportunity to testify on the issue of the provisions of intermittent services for Home Health Benefits.

As the Medicare Part A Subcontractor to the Blue Cross and Blue Shield Association for the State of California, we have eighteen years of experience with applying the regulation regarding Home Health Care and the definition of Intermittent Service.

This afternoon, I will discuss with you the intermittent issue, our interpretation of the regulation, our experience in applying the guidelines and the procedures we apply in order to monitor and complete on-going education to the home health provider to assure they understand and follow the guidelines.

If I might quote the regulation from HIM-11, Revision 124, March 1981, Section 204.1. This wording is essentially the same for Home Health Aides, HIM-II 206.5.

"Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in S 206.6) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3 week period, the Home Health Agency must forward medical documentation

justifying the need for such additional services and include an estimate of how much longer daily skilled service will be required."

As such, we believe the regulation offers the intermediary adequate latitude in assessing Intermittent service.

Blue Cross of California interprets the regulation to mean that covered care is rendered, when: the services that are provided take the skills of a nurse; the services are medically necessary and do not duplicate services provided by a physician, family member or the patient himself; and there is evidence that these services are closely monitored by a physician as to the continual need for the frequency. That is, new orders must be written by the doctor at least every 21 days or 3 weeks, as stated in the regulation.

Intermittent care, we believe, does extend itself to daily care and sometimes more frequently than once per day.

This interpretation has worked very well for Blue Cross of California, the provider, the patient, and for the Medicare program.

In a study conducted prior to Phase I implementation of prospective payment, we did an extensive review of all Home Health cases where daily skilled care appeared on the bill.

Our findings were the following:

1. Daily care was rendered primarily to patients recently discharged from a hospital.

2. The care rendered was primarily for extensive wound care.

3. The care could be rendered at home instead of a hospital setting, thus saving dollars to the Medicare program.

4. At least in California, the services provided were of a much higher level than in a skilled nursing facility, which in some circumstances refused to take these patients, because of the intensity of the services required.

5. Care in the majority of cases became less intensive within the 21-day timeframe and was no longer needed daily.

   Although in some instances, primarily for patients with a diagnosis of cancer where healing is slower, the daily care extended beyond the 21 days allowed in the regulation. These exceptions were extensively reviewed case-by-case and a determination made as to coverage issues. All care reviewed in these cases was determined to be skilled nursing services and not psychological or emotional support services.

6. In many instances, according to our study, when care became less intensive, it was due to the Home Health Agency's education of family members to perform these skilled services.

7. Home Health Agencies were receiving much sicker patients than had been the case in the past. We found that the care was necessary and, because it was rendered in a home setting, was less expensive than if the patient

remained hospitalized. However, we do understand that others throughout the country appear to define this regulation differently than we and our HCFA Regional Office in San Francisco do. This difference causes us some concern.

While this study was completed prior to the implementation of Phase I of Prospective Payment System for acute hospitals, in our 6 months of experience with DRG's, we are finding that the trend of sicker patients entering Home Health Agencies continues. These patients are being discharged earlier and need more daily skilled services during the 2 to 3 week period the Regulation allows for these services.

Throughout our years of experience, we have had a number of compliance audits completed by nurses for the Health Care Financing Administration, San Francisco Office, to determine the appropriateness of our interpretation of this regulation. We have never experienced any compliance problems and have demonstrated that the daily care rendered has been both appropriate and medically necessary.

Blue Cross of California has several procedures in place to ensure the continuation of compliance for intermittent care. I'd like now to take a few minutes to discuss these.

First, we have a very intensive Medical Review program in place that is done by registered nurses who understand home care.

Our sample procedures include a 20% random sample of all home health providers. If a provider loses a favorable waiver status due to this sampling, we do a 100% screening of all bills. All new agencies submit to a 100% screening for the first 3 months of participation in the Medicare program.

Further, we require submission of the Treatment Plan with all bills, and for any bills or services denied we will screen 100% of all subsequent bills for that particular patient.

All service for Physical, Speech and Occupational Therapies require a review by an allied health professional who is an expert in the particular field.

We conduct on-going on-site visits for the purpose of auditing sample bills and medical records.

In addition, since the early seventies, we have enjoyed a very fine working relationship with the California Association of Health Services at Home (CAHSAH). This relationship includes a working committee to discuss issues of providing home health care in an open forum setting that is educationally relevant to both the intermediary and the providers. This committee meets regularly on a quarterly basis, and monitors problem areas and helps home health agencies to solve problems with coverage issues on questionable cases.

Blue Cross of California also conducts monthly workshops for the purposes of helping the home health agencies in interpreting the regulations, solving and explaining confusing issues and helping agency staff, physicians, nurses and other health professionals to document care appropriately.

In the months ahead, Blue Cross of California will be implementing a new software system to further enhance our ability to monitor home health care. We have begun to finalize new review procedures that allow us to look at all home health providers in an appropriate manner. We have taken a look at historical compliance by these providers

and divided them into four categories (A-D) and will monitor them in four different ways. Those providers who historically have had few or no problems with compliance will be reviewed once each year (Category A) on-site to determine waiver status, while providers in Category D will be subject to 100% audit of all records. The review procedure for Categories B and C are in between, but will be subject to focused review, dependent upon the specific problem areas of the agencies.

In 1985, we will have the capacity to perform computerized edits for review of pre-payment Home Health bills.

In summary, Blue Cross of California believes that Home Health is being utilized as an "instead of" benefit rather than an "added-on" benefit and is saving the Medicare program dollars by allowing patients access to skilled care in the home.

As we continue to see earlier discharges, appropriate skilled Home Health care will become more and more critical. The regulation appears to allow us to make the appropriate determination for the medical necessity of daily care.

Our experience is that this benefit works well as an alternative to hospital care. Our concern is the medical necessity of daily visits may extend beyond wound care, but probably not beyond the 21 days identified in the regulation except in those cases where it is proven to be medically necessary.

Thank you for your attention.

Senator DURENBERGER. Mr. Jacoby, now that we have heard about the problems from three sides of it, do you have a recommendation for us as to how we can resolve this dispute over intermittent care?

Mr. JACOBY. I think, if I may, I would suggest that what we probably have here is a need for more effective communication than we are currently engaged in between ourselves and the home health agencies. As I listened to the testimony here, I concluded, as I am sure most everyone did in this room, that to the extent that the experiences of these home health agencies were actual as described, that's a serious indictment of the intermediaries. I don't question that the members of the home health agency group that appeared here today believe what they said happened in that way. However, I feel confident that if we were able to address the specific cases that were mentioned here, the majority we could probably explain in an understandable manner, using the guidelines of the program.

There is confusion. For example, when the members of the home health agency groups repeatedly said that the intermediaries, not uncommonly, use 3 weeks as a definitive cutoff point, I have to question that. Not their sincerity, their accuracy. It is in a sense a cutoff point. The intermediaries are required under their guidelines to examine a case at that time and require certain types of documentation. Now in that process of examination and requesting of documentation, things could get off the track to the point where the intermediary legitimately and properly denies the claim under program guidelines. But that doesn't mean that every intermediary is refusing or even a majority are stopping payments arbitrarily at that period.

Senator DURENBERGER. But I am left somewhat vague on whether the problem is benefit design, using that in a general sense, and we ought to take a little better look at designing the benefit structure so that it conforms a little bit better with reality; particularly, given the impact that prospective payment may have on hospitals. Or is it a difficulty that some intermediaries are having and feeling uncomfortable having HCFA look over their shoulder about how they interpret coverage for the providers in their area? Or is it that the intermediary employs a bunch of dentists who are not employed because of competition in the health care field to go over these things, and they don't know what they are doing? Or is it some combination of all of those?

Mr. JACOBY. I think it is a combination of all of those, Senator. I do feel, though, that the major underlying issue here is an unmet need. The medicare program is limited not only in the health care benefit area, but in other areas—hospital care and skilled nursing care. It is not unlimited care. And when care is denied because limits are reached or qualification factors are not present, there is dissatisfaction. And the stories about the beneficiaries who suffer as a result of this are.very touching and very emotional. But there is only so much money, and the program does have limits.

Senator DURENBERGER. If it is some of all of this, then obviously with the exception of Tennessee, Connecticut and California, who are all well staffed in their intermediary function, what kind of people are hired by Blue Cross and what kind of training do they

have as reviewers in order to make the judgments they are required to make?

Ms. ST. GERMAIN. In California, the manager of the home health medical review is a home health nurse who was head of home health agency. All of the medical review nurses that we hire do have clinical home health experience.

Senator DURENBERGER. In Connecticut?

Mr. ANDERSON. In Connecticut the supervisor of the medical review department is an RN with prior hospital and home health experience. Her staff consists of RN's with experience.

Senator DURENBERGER. And in Tennessee?

Mr. WILLIAMSON. In Tennessee, the supervisor of our medical review department is an RN with home health and hospital experience. In fact, she operated or managed a home health agency. And all of our RN's have home health experience that review home health claims.

Senator DURENBERGER. All right.

Anybody want to add anything else from the intermediary viewpoint that isn't in your written statements or your summarizes?

[No response.]

Senator DURENBERGER. If not, I thank all four of you for being here, and I appreciate it very much.

Next we will hear from Mr. Streimer and Mr. Kappert. I will just quote you briefly from the prepared statement by Patrice Feinstein, Associate Administrator for Policy:

> Current concern about the intermittent care requirement is really one of flexibility versus specificity in its administration. It is not difficult to develop and apply rigid guidelines to control the exact amount of home health care that can be provided. Specific guidelines require a little judgment. Questionable cases that might later be subject to appeal are virtually eliminated. However, we all know the problems such an inflexible system can create.

Well, it looks like we are caught here some place by trying to do good. And I wonder if the two of you wouldn't mind reacting to—I don't ask you to react to specific allegations or anything like that, but principally to listen to the testimony of the witnesses and to their responses to questions, and then perhaps explain to us why we have some of these problems, and what may be some of your frustrations in looking at the law and trying to implement it through an intermediary system and so forth.

I don't know who wants to go first.

Mr. KAPPERT. Certainly we are impressed by the anecdotal information and so forth, particularly, what the home health agency people presented.

I think that the actions that Ms. Feinstein laid out when she was here addressed the problems we heard. Certainly the latest guidance that we sent to intermediaries is very specific about the fact that there is no cutoff point at two to three weeks. Indeed, that is the point at which you get more information to determine what the long-term course of treatment is.

I think also the anecdotes lead you to believe that almost nothing is being covered. In our longer statement, we show that indeed the dollars that we are spending on this benefit are exploding. The fact is that while the denial rates are very small, we are also processing in excess of 5 million bills a year. And there are many visits

contained on each bill. So there are an awful lot of people getting a lot of service. It is the question of cases where, as Mr. Jacoby eloquently stated, there is a great deal of emotion involved, where something bad happens to people. All of these things, obviously, become very important and we don't want to dismiss them.

But, at the same time, we are spending an awful lot of dollars and paying for an awful lot of visits and the number of home health agencies are growing by leaps and bounds so that the benefit cannot be so constrained as the anecdotes might lead you to believe.

Senator DURENBERGER. Can you give me any other dimensions? You run the operations of this program. You have given me 5 million claims and lots of visits. Any idea of how much it is costing us to process this particular-reimbursement system?

Mr. KAPPERT. In terms of administrative costs?

Senator DURENBERGER. I guess so. Anything that doesn't actually go to patient care.

Mr. KAPPERT. The administrative amount would be very, very small. Our overall administration is about 1 percent of the benefit dollars or less. Certainly home health, as large as it has become, is not one of our largest cost areas, either in terms of dollars, although those, as has been indicated, are growing very quickly. The cost per bill for processing by intermediary is under $4 a claim. There is really not a whole lot of money going into administration.

Senator DURENBERGER. $4 a claim. That's the total compensation to the intermediary?

Mr. KAPPERT. Yes.

Senator DURENBERGER. That is less than 1 percent of the claims paid by that intermediary?

Mr. KAPPERT. That's an overall average. I don't have the specific numbers on home health. I'm not sure that we break it down that fine. That would include hospital bills, nursing homes, the whole business.

Senator DURENBERGER. I see.

Bob, you want to add something?

Mr. STREIMER. Yes, I wanted to make a few points. One is that the legislation changed in 1980. In 1981 we paid for 26.2 million visits in this country and in 1983 we paid for 37.1 million visits. I think there are a couple of interesting points that were made by the representatives from the home health agencies. I wrote down the quote: "Home health care has changed dramatically since the enactment of medicare." Medicare has not changed dramatically since the enactment of medicare. The Congress removed the 3-day limit, the 3-day prior hospitalization, and the 100-visit limit. However, the descriptions of the qualifications for the benefits remain essentially the same as they have since 1965.

The benefit was never intended to provide daily skilled medical care in the home. The benefit has always been described as intermittent care, intermittent skilled care.

Senator DURENBERGER. Maybe that isn't a bad idea to do that, but you are saying that wasn't the design.

Mr. STREIMER. That was not the design of it. And I guess the question now is can we afford to do something like that.

The other thing that I think some of the data will bear out is that capacity is increasing dramatically in home health. I don't know whether the supply or the demand is coming first. I think there are several studies that are underway now on the subject and hopefully we will find something out about that.

With respect to prospective payment, we have recently let a contract with Abt Associates to design a study, a national study, on different prospective payment methodologies for home health. And they are exploring many of the things that were mentioned today by the representatives of the home health groups.

Senator DURENBERGER. I get very squeamish when I hear that Tennessee is going on a certificate of need just because of this explosion. Now maybe it shouldn't have exploded the way it did 200 and something to 400 and something in one State. And maybe you are right. Maybe it's one of those statistics where it is $30[illegible] less for skilled nursing facilities than home health.

But I hope the home health industry understands that at least for one Senator my deep concern is for the whole business of substitution. And I think I have articulated this before when we had our big hearings last December or January or whatever it was when we were listing to our colleagues' solutions to these problems. That we can't just add to the cost to put somebody in what we all presume is a more cost effective setting. What our deep concern for is an appropriate substitution of services so the right person gets in the right place for the right length of time. And then everybody gets improved care at a lower cost.

And I get the feeling we are edging in that direction, we are trying to get in that direction. But I get the feeling from what you have just said, Bob, and from some of these statistics that we may have improved the quality of care for people out there, but we haven't done a thing to tip the line on the cost of that care. Is that what I am hearing you say?

Mr. STREIMER. I think in part. I think your point on the substitution is something we are very concerned about the General Accounting Office in their report on home health made clear that an appropriately targeted unit of home health service, was certainly more economical than a unit of institutional service. They questioned whether the Federal Government or the intermediaries could target so specifically as to know when it would be appropriate and when you just would not be providing additional care.

In addition, we are concerned that anytime we use a new number such as 21 days, or 35 days, or 45 days as a new guideline, that immediately the level of daily care moves to that level for too large a number of cases, and that the cost of that kind of activity is prohibitive also.

Senator DURENBERGER. I can understand that.

Mr. KAPPERT. I think another statistic that concerns us is that the average cost of a home health visit is surpassing the average cost of a day in the nursing home. Not that there are not other social benefits——

Senator DURENBERGER. Can you prove that?

Mr. KAPPERT. Yes.

Senator DURENBERGER. You have the data for that? Say that again.

Mr. KAPPERT. The average cost of a home health visit can exceed the cost of a day in a nursing home.

Senator DURENBERGER. That's a little different. You said can exceed it. I think the first time you said, "it is exceeding it."

Mr. KAPPERT. We have not prepared the numbers.

Senator DURENBERGER. Would you prepare some numbers on that for us?

Mr. KAPPERT. I think in the 1984 and 1985 budget it was $45 versus $48. It was that close. So that's why I'm saying it could have surpassed it this year.

The budget figures for skilled nursing facility per diem costs are $62 for fiscal 1984 and $65 for fiscal 1985.

The cost limit on skilled nursing visits to the home for periods beginning on or after July 1, 1984 is $62.15 for non-MSA locations and $53.54 for MSA locations. The figure is higher or lower for any particular provider depending upon the wage index that applies in its location.

Therefore, during the common time period involved, it is entirely possible that some home health skilled nursing visits will cost more than a day of care in a skilled nursing facility in the same or another area.

Senator DURENBERGER. All right.

Just one last question on the number of intermediaries. Do either of you want to defend why we would all be better off with 10 intermediaries instead of 47?

Mr. KAPPERT. Absolutely. We are 100 percent with that.

Senator DURENBERGER. Tell me why it's better.

Mr. KAPPERT. I think most of the people said today that, indeed, the guidelines are not all that bad, particularly the ones that we have most recently put out there; that if there is a problem, it is because those guidelines are still nonetheless applied different by different intermediaries.

If we reduce the number of intermediaries, we will reduce the amount of that differentiation.

Senator DURENBERGER. Why? One example, I imagine, was somewhat exaggerated, but you had three visits a day in New York versus, once a day for 2 weeks or something like that in some other State. I mean suppose the same intermediary has both of those States? Are we going to do three visits a day in New York for everybody in a 10-State area or a 5-State area?

Mr. KAPPERT. I think there will be 10 differences instead of 47, if indeed it's that explosive. But beyond that, we can sit down a whole lot easier with 10 and say this is what we mean. And we can check up on 10 better than we can check up on 47.

Senator DURENBERGER. Yes, but looking at it from the other end. I mean the folks in Nashville, it seems to me, can get along a heck of a lot better with Blue Cross of Tennessee than with Blue Cross of Georgia or Texas or something like that, whoever gets to be the intermediary or Ross Peroe. [Laughter.]

I mean isn't there an argument to be made that way too? If you just get your signals straight, how come 10 is more magic than 47?

Mr. KAPPERT. Remember, we started out with something like 73. And it was at congressional direction that we reduced that to regional intermediaries.

Senator DURENBERGER. I'm arguing with the Congressmen. I wasn't on this conference committee. I didn't decide that.

Mr. KAPPERT. I'm talking about the move we made from 73 to 47. We moved from 73 to 47. We still get the same amount of complaints. We think going to 10, then, may be the solution.

Senator DURENBERGER. I'm just concerned to know whether there is a logic there. I see HCFA doing the same thing with peer review organizations. People didn't like 200 or whatever it was, so they said, well, let's have 1 in each State. And the reality is that in some of those States it may make a heck of a lot more sense when they have three PRO's operating. But I can't get through this bureaucratic mindset at HCFA that says big is better or fewer is better than a whole lot and so forth. And I want to be sure that that isn't a problem in this case. That you are not just in the 10 is better than 47 game.

Mr. KAPPERT. We think we can better manage it that way. We are very happy with the language of the committee.

Senator DURENBERGER. All right. Any other comments either of you want to make?

Mr. KAPPERT. We would like to state emphatically that there is no target for denials for any intermediary. I think that was alluded to. There is absolutely no target at any level for denials of medicare claims of any kind under parts A and B.

And this question about whether we have recently become much more difficult, certainly our numbers don't bear that out. For example, the denial rate for home health in 1979 was 1.9 percent. In 1980 it was 2.2 percent. It remained that way in 1981. In 1982, it was down to 1.5. And in 1983, down to 1.2. So there is an awful lot of care being paid for out there. And I think when you hear the anecdotes you are hearing things that are bearing at the margin.

Mr. STREIMER. I would like to make a point also in terms of the nature of the benefit and how it has changed over the years. In the early 1970's, the mix of skilled services versus home health aide, services was 75 percent skilled, 25 percent home-health aides. By 1980, the home-health aide services had grown to 32 percent. Currently, it's approaching 50 percent of the total for type services. So while home health agencies are getting more sophisticated, the largest amount of services rendered tend to be moving toward the less skilled services and not the more skilled services.

Senator DURENBERGER. The last thing. When I asked Mr. Jacoby what other problems there were between intermediaries and providers, he said the homebound program. Are you aware of that?

Mr. STREIMER. Well, it's interesting because all five of the organizations that were represented in the September meeting with Dr. Davis advised very strongly not to change the existing homebound guidance. Our Inspector General has advised us that he believes that the fiscal intermediaries are paying for far too many cases that are not homebound. We are investigating that. But we are not at the present time changing our manual instructions.

Senator DURENBERGER. All right. Thank you, gentlemen, for giving me an extra hour and a half of your afternoon. I appreciate it a lot.

Thank you, everyone else. The hearing is adjourned.

[Whereupon, at 3:51 p.m., the hearing was concluded.]

[The following was received for the record:]

CANCER CARE, INC.
AND THE NATIONAL CANCER FOUNDATION, INC.,
New York, NY, June 29, 1984.

Re Medicare's Home Health Benefits Public Hearing, June 22, 1984.

Senator DAVID DURENBERGER,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate.

Cancer Care, Inc. is grateful for this opportunity to express its criticisms of Medicare's home health benefits. We commend you for convening a hearing on this subject, thereby facilitating a public exploration of this complicated and important issue.

Cancer Care, Inc. is a voluntary social agency with direct service offices in New York City, Woodbury, Long Island, and Everson in New Jersey. For over forty years we have offered comprehensive social services to cancer patients and their families. This includes help with planning for the patient's care at home, individual and group counseling for both patients and relatives, as well as bereavement counseling. In addition, we give financial assistance to eligible families to help them pay for a home-care plan so that the patient may be cared for at home.

More than 50% of our patients are over 65 and Medicare eligible. Therefore, our social workers must constantly cope with the gaps in Medicare's home health coverage when helping to work out plans for the care of an elderly cancer patient at home.

The inadequacy of Medicare's home health benefit begins and ends with the fact that it is geared to acute, short-term illnesses rather than addressing the realities of the health conditions and needs of so many of the elderly—that is, long-term, drawn-out and chronic illnesses. Such illnesses, and this can include cancer, do not necessarily require a skilled service at home, but do require more than part-time or intermittent care by a home health aide.

As you know, in order to qualify for home health aide services a patient must require a skilled service such as nursing, speech or physical therapy. However, many if not most, of the elderly cancer patients in our caseload do not need a skilled service on an ongoing basis. But, they frequently do need a home health aide or a homemaker and help with personal care. In addition, they must be homebound in accordance with Medicare's stringent definition of that term. Here too, many cancer patients do not qualify.

Another irony is that they frequently need more than part-time, intermittent services of the home health aide. This can be because of the patient's physical distress and resulting dependency, but also because of the unavailability of much help from family or friends, the so-called informal caregivers.

We can give you example after example of situations which require financial assistance from Cancer Care to enable an elderly cancer patient to be cared for at home because the patient is ineligible for Medicare's home health services.

The following is a description of one of these situations: An 80-year old woman in an advanced stage of carcinoma of the breast was being cared for at home by her mentally retarded son. In addition, a very loving and supportive, albeit multi-health-problem family, was devoting every possible moment to ensure her ability to stay at home until her death. One daughter-in-law, a nurse, had even moved in to assist in caring for the patient even though she and her husband had 5 children, one of whom had lupus and another rheumatoid arthritis. Since the patient required only "custodial care," that is assistance with daily hygiene and supportive activities, she was thus ineligible for Medicare coverage for her home care needs. When her family presented for assistance from Cancer Care, they were at the point of exhaustion, physically, financially and emotionally. Cancer Care helped this family pay for a home health aide.

There also are many instances when we offer financial assistance to augment a Medicare-reimbursed home care plan provided by a home health agency. In these cases, the home health agencies have been able to substantiate the need for a skilled service plus some part-time home health aide services. But, knowing that the patient really needs more help, the home health agency turns to us to augment this plan. Just as frequently, this procedure is initiated by us.

Cancer Care is a very unique agency both in terms of the counseling services we provide, as well as the financial assistance we make available when this is necessary. Also, in contrast to other philanthropic organizations, we stay with the patient and family as long as we are needed. We are providing help which is sorely needed by so many families coping with cancer, and in so doing we are fulfilling the role and obligation of the voluntary sector in a manner barely duplicated elsewhere. We

might add here that we do not receive any government monies and have supported our services by personal and foundation contributions.

From July 1, 1983 through June 15, 1984 we expended $766,108 in helping 702 patients; a large majority of these patients were on Medicare. We dread to think what might have happened to these patients and their relatives if we had been unable to assist them.

We strongly believe that Medicare should improve its home health benefit in order to better serve elderly patients who need home care. By so doing, Medicare will be more adequately fulfilling its promise to the elderly and in many instances will help patients with relatively small incomes live out their lives with dignity and without being reduced to poverty.

We are aware that a recent HCFA study has estimated that Medicare's expenditures for home health care in 1983 may be 25% higher than it was in 1982, higher rate of increase than in other reimbursement categories. However, the percentage of Medicare reimbursements that goes for home health is still very small. The importance of understanding the reasons for this higher rate of increase should not obviate the need for broadened home health services for Medicare patients. The necessity for this is made even more urgent by the institution of DRG's and the expectation that patients will be discharged from hospitals earlier and sicker than in the past, requiring more than part-time and intermittent home care.

Cancer Care, Inc. has for years advocated for a broadened concept of home health services under Medicare. Attempts to liberalize Medicare's home health benefits go back to at least 1974 with Senator Muskie leading an effort towards removing the skilled nursing care requirement. Senator Church was also heavily involved as well as Representative Pepper. In recent months we have expressed our support of certain Federal legislative proposals which would liberalize the "part-time, intermittent" restriction on home health services. We are referring to Representative Waxman's H.R. 3616 and Senator Heinz's S. 2338, The Home Care Protection Act. The latter was clearly in response to what appeared to be HCFA's attempt to tighten the guidelines and regulations which had allowed for some amount of daily home health care in situations of acute or terminal illnesses. Unfortunately, Senator Heinz's amendment, a compromise from his original proposal, did not survive the budget compromise.

In closing, we urge you to work towards a broader definition of Medicare's home health benefits. Although this will increase the amount of Medicare dollars spent on home health care, it will decrease instances of spending down to Medicaid eligibility and institutionalization which eat up public monies. And, of equal importance, expanded home health services under Medicare will help the elderly live out their remaining days in familiar surroundings, and with much less anxiety and tension.

Again, we want to express out thanks for this opportunity to express our views.

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